# Prison Rape Elimination Act (PREA) Audit Report
## Community Confinement Facilities

☐ **Interim** ☒ **Final**

**Date of Report** 6/28/18

## Auditor Information

| | |
|---|---|
| **Name:** Talia Huff | **Email:** talia360cc@gmail.com |
| **Company Name:** Mid-America Correctional Consulting | |
| **Mailing Address:** PO Box 393 | **City, State, Zip:** Larned, KS. 67550 |
| **Telephone:** 785-766-2002 | **Date of Facility Visit:** 4/09/18-4/10/18 |

## Agency Information

| | | | |
|---|---|---|---|
| **Name of Agency:** CoreCivic | | **Governing Authority or Parent Agency** *(If Applicable)*: N/A | |
| **Physical Address:** 10 Burton Hills Blvd | | **City, State, Zip:** Nashville, TN 37215 | |
| **Mailing Address:** 10 Burton Hills Blvd | | **City, State, Zip:** Nashville, TN 37215 | |
| **Telephone:** 615-263-3000 | | **Is Agency accredited by any organization?** ☐ Yes ☒ No | |
| **The Agency Is:** | ☐ Military | ☒ Private for Profit | ☐ Private not for Profit |
| ☐ Municipal | ☐ County | ☐ State | ☐ Federal |

**Agency mission:** Reducing recidivism and building communities is at the heart of our reentry mission. Through our residential and nonresidential services, we can help people successfully reintegrate after prison or avoid being incarcerated in the first place.

**Agency Website with PREA Information:** www.corecivic.com

### Agency Chief Executive Officer

| | |
|---|---|
| **Name:** Damon Hininger | **Title:** President/CEO |
| **Email:** damon.hininger@corecivic.com | **Telephone:** 615-236-3301 |

### Agency-Wide PREA Coordinator

| | |
|---|---|
| **Name:** Eric Pierson | **Title:** Sr Director, PREA Programs and Compliance |

| | |
|---|---|
| **Email:** eric.pierson@corecivic.com | **Telephone:** 612-263-6915 |
| **PREA Coordinator Reports to:**<br>John Robinson, Vice President Correctional Programs | **Number of Compliance Managers who report to the PREA Coordinator** |

## Facility Information

| | | | |
|---|---|---|---|
| **Name of Facility:** Carver Transitional Center | | | |
| **Physical Address:** 400 S. May Ave. Oklahoma City, OK. 73108 | | | |
| **Mailing Address (if different than above):** N/A | | | |
| **Telephone Number:** 405-232-8233 | | | |
| **The Facility Is:** | ☐ Military | ☒ Private for Profit | ☐ Private not for Profit |
| ☐ Municipal | ☐ County | ☐ State | ☐ Federal |

| | | | |
|---|---|---|---|
| **Facility Type:** | ☐ Community treatment center | ☒ Halfway house | ☐ Restitution center |
| | ☐ Mental health facility | ☐ Alcohol or drug rehabilitation center | |
| | ☐ Other community correctional facility | | |

**Facility Mission:**

**Facility Website with PREA Information:** www.corecivic.com/facilities/carver-transitional-center

**Have there been any internal or external audits of and/or accreditations by any other organization?** ☒ Yes ☐ No

### Director

| | |
|---|---|
| **Name:** Chris Villalobos | **Title:** Assistant Regional Director/Acting Facility Head |
| **Email:** Christopher.villalobos@corecivic.com | **Telephone:** 405-232-8233 |

### Facility PREA Compliance Manager

| | |
|---|---|
| **Name:** Michael Moriarity | **Title:** PREA Compliance Manager |
| **Email:** Michael.moriarity@corecivic.com | **Telephone:** 405-232-8233 |

### Facility Health Service Administrator

| | |
|---|---|
| **Name:** N/A | **Title:** N/A |
| **Email:** N/A | **Telephone:** N/A |

### Facility Characteristics

| | |
|---|---|
| **Designated Facility Capacity:** 300 | **Current Population of Facility:** 289 |

| | | | |
|---|---|---|---|
| **Number of residents admitted to facility during the past 12 months** | | | 789 |
| **Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:** | | | 789 |
| **Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:** | | | 789 |
| **Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:** | | | 789 |
| **Number of residents on date of audit who were admitted to facility prior to August 20, 2012:** | | | 0 |
| **Age Range of Population:** | ☒ Adults<br>18-70 | ☐ Juveniles | ☐ Youthful residents |
| **Average length of stay or time under supervision:** | | | 8-12 months |
| **Facility Security Level:** | | | Non-secure |
| **Resident Custody Levels:** | | | Min/Med |
| **Number of staff currently employed by the facility who may have contact with residents:** | | | 44 |
| **Number of staff hired by the facility during the past 12 months who may have contact with residents:** | | | 68 |
| **Number of contracts in the past 12 months for services with contractors who may have contact with residents:** | | | 0 |

## Physical Plant

| | |
|---|---|
| **Number of Buildings:** 5 | **Number of Single Cell Housing Units:** 0 |
| **Number of Multiple Occupancy Cell Housing Units:** | 0 |
| **Number of Open Bay/Dorm Housing Units:** | 10 |

**Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):**

Carver Center has 37 cameras located throughout the facility; all inmate dorms and hallways as well as most other common areas.

## Medical

| | |
|---|---|
| **Type of Medical Facility:** | Medical services are obtained offsite. |
| **Forensic sexual assault medical exams are conducted at:** | Local hospital |

## Other

| | |
|---|---|
| **Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:** | 39 |
| **Number of investigators the agency currently employs to investigate allegations of sexual abuse:** | 17 |

# Audit Findings

## Audit Narrative

*The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.*

CoreCivic contracted for a PREA audit to be conducted of the Carver Transitional Center, halfway house, in Oklahoma City, Oklahoma. This audit was conducted by dual-certified PREA auditor Talia Huff. The onsite portion of the audit occurred 4/09/18-4/10/18. CoreCivic is a private correctional agency that is contracted to operate correctional facilities across the country. Carver Transitional Center is a CoreCivic community-based residential halfway house; defined by the PREA Standards as a community confinement facility. According to CoreCivic's latest annual newsletter, the agency operates 54 safety facilities and 30 community facilities (includes leased, managed, and owned) and has a presence in 21 states. The Carver Transitional Center was acquired by CoreCivic in October 2015. Prior to this acquisition, the facility was operated by Avalon Correctional Services and received its first PREA audit under that agency in October 2015.

Approximately seven weeks prior the onsite audit, the auditor provided audit notices (in English and Spanish) to be posted in all living units, facility entrance, visitation areas, medical areas, mental health areas, and other common areas. The notices provide auditor contact information in which inmates, staff, and visitors can write confidentially regarding sexual abuse and sexual harassment at the facility. The notices were provided to the PREA coordinator, who relayed them to the facility. The auditor received confirmation by the facility PREA compliance manager that the notices were posted on 2/26/18; seven weeks prior to the audit and said notices were observed throughout the auditor's site review. No correspondence was received by the auditor. Pre-audit documentation, the *Pre-Audit Questionnair*e (PAQ) and additional supporting documentation, was provided via flash drive which was received by the auditor five weeks prior to arriving onsite. Pre-audit documentation was received in an efficient and organized manner, with standard-by-standard folders distinguishing relevant primary and secondary documentation. Correspondence between the auditor, the PREA coordinator, and PREA compliance manager occurred throughout the pre-audit phase. Prior to arrival, the auditor submitted a tentative audit schedule to the facility to outline onsite audit activities. On 4/09/18 the auditor reported arrived at Carver Transitional Center to initiate the onsite audit. An in-brief meeting was held the first morning with facility leadership and the agency PREA coordinator in which introductions were made and the audit process and methodology were discussed. Present for the in-brief was: Eric Pierson, PREA coordinator; Michael Moriarity, PREA

compliance manager; Chris Villalobos, assistant regional director/acting facility head; and management and support staff.

Following the in-brief, the auditor conducted the site review (performance-based tour) of the facility, accompanied by facility leadership. The site review spanned the entirety of the campus which mostly consisted of all inmate living areas, recreation areas, dayrooms, kitchen and dining hall, office areas, and laundry. PREA signage was observed throughout the facility ensuring that reporting information was adequately visible for all inmates, staff, and visitors. There was also a small plaque above each inmate phone with the PREA hotline number. Through the site review, the auditor gleaned additional information in areas such as intake (where inmates arrive and receive PREA information), inmate work areas (i.e. kitchen), bathrooms and showers, camera monitoring areas, and case management. Cameras and mirrors were seen in many places to enhance inmate supervision and there were minimal blind spots and isolated areas (with no camera coverage) noted.

Following the site review, interviews of leadership and specialized staff were conducted. The PREA coordinator and PREA compliance manager were available at all times for auditor clarification and consultation and helped to ensure an efficient audit. Inmate rosters were provided to the auditor which were used by the auditor to select random inmates for interviews. Twenty-one inmates were selected randomly from the ten dorms and two targeted inmate interviews were conducted as well, pursuant to the PREA audit methodology. Twelve random staff were chosen by the auditor for interview and included a cross-section of positions and ranks.

Prior to arrival, the auditor requested lists of staff and inmates to include the following: full inmate alpha roster (alphabetically and by living unit), full staff roster of security and non-security staff, lists for specialized staff interviews and targeted inmate interviews, pursuant to the PREA audit methodology. A comprehensive list of all allegations and investigations was also requested, to include all allegations of inmate sexual abuse and sexual harassment with the type of allegation and case disposition information. The Carver Center had one allegation of inmate-on-inmate sexual abuse which was pending during the pre-audit phase but determined to be unsubstantiated. The auditor reviewed the investigative file while onsite as well as all other documentation requested. All requests for documentation were promptly accommodated. Documentation requests included inmate screening, education, medical, and mental health records; staff training records; personnel records to include background checks and hiring information.

Prior to arrival and while onsite, the auditor made contact with external entities such as the Young Women's Christian Association (YWCA); the entity designated for forensic examination, crisis intervention, and outside emotional support services. Just Detention International (JDI) was contacted as well and reported no inmate contact from the Carver Center.

At the conclusion of the onsite audit, an exit briefing was held with facility leadership and the PREA coordinator. Preliminary findings and observations were discussed, and the process of

the post-audit phase was reiterated; issuance of the Interim Report, corrective action period, and Final Report.

## Facility Characteristics

*The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.*

The Carver Transitional Center is a community confinement facility operated, via contract with Oklahoma Department of Corrections, by CoreCivic. CoreCivic acquired the Carver Center in October 2015. Prior to that it was operated by Avalon Correctional Services under which they received their first PREA audit in 2015.

The Carver Center campus consists of five buildings and has a capacity of 300 male inmates; 30 inmates per barracks-style dorm. There are 10 dorms. The inmate population on the first day of the audit was 289. The Carver Center serves an age range of 18-70 years of age. The Carver Center reported their average length of stay as 8-18 months and that 789 inmates were admitted to the facility within the 12-month reporting period prior to this audit. Approximately 44 staff are currently employed by the facility and they have no contracts for inmate programs or services. The facility uses approximately 39 volunteers that have contact with inmates, for varying programs such as religious programs, Alcoholics and Narcotics Anonymous, life skills, and many other groups and programs designed to increase inmate success in reintegrating into the community.

There are five buildings; buildings A, B, C, D, and E. The ten inmate dorms are located in building E. Building E has a control room which is manned by security staff and has camera viewing access. It contains a laundry hallway adjacent to the bathrooms and shower area. The bathroom stalls are located down an adjacent hallway and is a somewhat isolated area. There was camera view of the entrance to the area but was noted that there were minimal supervision capabilities in the bathroom stall area. The shower design is a large square open room with "gang" showers. Building E also has a "day area" which is a common area in the middle of the building and there is outdoor recreation area as well. Both have camera viewing capabilities. The ten dorms generally house the same classifications of inmates which have to meet criteria for admission to this step-down type placement, post-incarceration. Dorm five is one exception as it is the restricted dorm that houses inmates who have not gained employment (as required) or that have lost privileges due to facility rules violations. Generally, inmates have gained employment and many leave campus most days to go to work. Building D consists of the kitchen and dining hall, case management offices for six case managers, offices of two employment specialists, and administrative offices. Buildings A, B, and C are vacant buildings that are no longer used with the exception of some designated for supplies storage. There is limited access to buildings A, B, and C, which consists of the chief, lieutenants, and maintenance.

## Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Auditor Note:** No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

### Number of Standards Exceeded: 9

115.211, 217, 218, 231, 232, 242, 266, 286, 288

### Number of Standards Met: 32

115.212, 213, 215, 216, 221, 222, 233, 234, 235, 241, 251, 252, 253, 254, 261, 262, 263, 264, 265, 267, 271, 272, 273, 276, 277, 278, 282, 283, 287, 289, 401, 403

### Number of Standards Not Met: 0

### Summary of Corrective Action (if any)

Interim Report
CoreCivic; the agency, and the Carver Transitional Center; the facility, have made remarkable efforts to comply with the PREA Standards and more so to make their best effort to ensure inmate sexual safety. Compliance at both the agency and facility level are exceptional. The two standards not met will require minor corrective action which is not to be overshadowed by the many areas in which the standards have been exceeded.

Final Report
As of 6/12/18, the auditor received documentation satisfying all corrective action. Actions taken to satisfy this corrective action, for Standards 115.253 and 115.263, are outlined in those respective standard discussions below. With this accomplishment, the Carver Center is now substantially compliant with all PREA Standards.

# PREVENTION PLANNING

## Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

**All Yes/No Questions Must Be Answered by The Auditor to Complete the Report**

**115.211 (a)**

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual

abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

**115.211 (b)**

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic Agency Policy Supplement (APS) OP 030601 *(effective 4/04/16)*
- Organizational Charts; agency and facility
- PREA coordinator job description

**Findings:**

115.211(a)

Both CoreCivic as well as the Oklahoma Department of Corrections (ODOC) functions as the agency for the Carver Center. The Carver Center operates primarily under ODOC policies and in some cases, the facility also adheres to CoreCivic Agency Policy Supplements (APS).

ODOC has implemented a zero tolerance policy in which the facility follows; ODOC PREA Policy OP 030601. ODOC OP 030601 establishes the agency's zero tolerance against inmate sexual abuse and sexual harassment. It contains definitions of prohibited behaviors with definitions related to sexual abuse and sexual harassment on pages 10-13. ODOC OP 030601 specifies that for purposes of reporting and investigation, "sexual assault" is categorized as "nonconsensual sexual acts" and "abusive sexual contact" for inmate-on-inmate allegations and "staff sexual misconduct" or "staff sexual harassment" for staff-on-inmate allegations. It was noted that these specific terms are from an older version of the *Survey of Sexual Victimization* (SSV) and is missing a category for inmate-on-inmate sexual harassment. ODOC OP 030601 does contain additional definitions for prohibited sexual conduct that comprises all inmate-on-inmate and staff-on-inmate sexual abuse and sexual harassment. Other PREA-related definitions can be found on pages 7-8 such: voyeurism, LGBQTI, lesbian, gay, bisexual, transgender, intersex, questioning, gender nonconforming, gender dysphoria, substantiated, unsubstantiated, unfounded. Sanctions for prohibited conduct were also found. ODOC OP 030601 asserts that the prohibited conduct applies to all employees, volunteers and contract staff; that sexual conduct between staff and inmates is strictly prohibited and is subject to administrative disciplinary sanctions and referral for prosecution. ODOC OP 030601 is a comprehensive 39-page policy containing many agency-specific methods of compliance and outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

115.211(b)

CoreCivic has appointed an upper-level PREA coordinator; Eric Pierson. Mr. Pierson reported that he has sufficient time and has authority to develop and oversee agency PREA compliance efforts. He works with each facility to address compliance issues, schedules and helps prepare for each PREA audit, and attends most audits as well. His position is dedicated full-time to PREA compliance efforts as the Senior Director for PREA Programs and Compliance. The auditor reviewed the agency organizational chart, which depicted Mr. Pierson as the PREA coordinator (PC) and showed his upper-level position within the agency structure. As well, his position description was provided for review which confirmed sufficient time and authority to develop and oversee agency PREA compliance. The PREA coordinator reports directly to the vice president of correctional programs.

Though, the community confinement standards do not mandate the appointment of a PREA compliance manager at the facility, CoreCivic still requires this appointment. At the Carver Center, Michael Moriarity is the PREA compliance manager (PCM). The auditor felt this was best practice and necessary not only so there is a designated person to handle allegations onsite but also to aid in PREA compliance efforts onsite. The facility organizational chart was provided for auditor review. It depicts Mr. Moriarity as the PREA compliance manager, that he is directly below the facility head, and reports to the facility head. Mr. Moriarity reported that he has sufficient time and authority to oversee facility compliance efforts, though at times meeting the task is challenging. He was very knowledgeable about many aspects of PREA compliance and expressed his team approach in working toward compliance.

The agency exceeds this standard due to its comprehensive PREA policy which also contains agency-specific direction and also because of the appointment of a PREA compliance manager which is not required under the Community Confinement PREA Standards but is in the best interest of the facility and maintaining sexual safety.

**Corrective Action:**
None required

## Standard 115.212: Contracting with other entities for the confinement of residents

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.212 (a)**

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes ☐ No ☐ NA

**115.212 (b)**

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".) ☒ Yes ☐ No ☐ NA

**115.212 (c)**

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- *FY 2018 Fixed Rate Service Contract between Oklahoma Department of Corrections and Carver Transitional Center*

### Findings:

115.212(a), (b)
Policy language relevant to this standard was not provided. This standard is applicable to the Oklahoma Department of Corrections (ODOC) considering ODOC as the agency since it contracts for the confinement of inmates *with* CoreCivic. Specifically, for the Carver Center, the ODOC has included in its contract the obligation to comply with the PREA Standards. The *FY 2018 Fixed Rate Service Contract between Oklahoma Department of Corrections and Carver Transitional Center* was provided for auditor review. Section 3.8 specifically addresses PREA. Section 6 addresses contract monitoring. Appendix A requires the Carver Center to follow ODOC PREA Policy OP 03061.

CoreCivic's PREA coordinator, designated as agency contract monitor pursuant to PREA, elaborated on contracts at the agency level and states that he is charged with overseeing and monitoring facility PREA compliance. He asserted that all CoreCivic-operated facilities have been audited and are PREA compliant (with the exception of current, ongoing audits). One newly acquired community confinement facility has not yet been audited but it will be scheduled soon. The CoreCivic PREA coordinator ensures that one-third of their facilities are audited each year. He was unsure of the current exact number of agency contracts but stated there are 60 facilities and all are PREA compliant.

### Corrective Action:
None required.

## Standard 115.213: Supervision and monitoring

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.213 (a)**

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
  ☒ Yes ☐ No

- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

**115.213 (b)**

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

**115.213 (c)**

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*
- 14-2 CC-I *Annual PREA Staffing Plan*
- Camera Locations map
- *2017 PREA Staffing Plan* (Post/Shift Assignments)
- Narrative Explanation of Staffing Plan

**Findings:**

115.213(a)
CoreCivic APS OP 030601 is the primary policy that outlines compliance with this standard. This policy asserts that CoreCivic will work in conjunction with the facility to develop a staffing plan that allows for adequate levels of staffing to protect inmates from sexual abuse. It addresses each provision of this standard with the addition of agency-specific language instructing practice and procedure. Consistent with this provision, the policy states that the staffing plan will consider: (1) The physical layout of each facility; (2) The composition of the resident population; (3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and (4) Any other relevant factors. The auditor did not, however, receive documentation of *how* the agency and facility considers each of these provisions in their staffing plan. The auditor received *2017 Staffing Plan* matrix, which showed the types and numbers of post assignments for each shift, but not documentation of the development of the staffing plan or the means in which the facility looked at their staffing through a lens of sexual safety, considering the four required elements of this provision and which are cited in policy. However, the auditor was provided with a narrative explaining the consideration of the required staffing plan elements as outlined in this provision. Some excerpts from the narrative explanation were as follows:

- *Camera numbers and locations were reviewed as well as the required number of counts and facility tours completed by staff daily.*
- *A summary of all PREA incidents for the previous year is compiled and attached to the draft of the PREA Staffing Plan so that the facility staff and reviewers can note any pattern as to the location of any sexual abuse incidents. For example, a repeat of incidents on a specific shift, in a specific housing area would result in additional staff resources being placed in that area.*

- *Consideration is given to anything learned from the Sexual Abuse Incident Review as far as adequacy of staff coverage or need for additional cameras. Other relevant factors considered included reviews of monthly SART Team meetings to identify and discuss any areas of concern regarding sexual safety.*

The facility reported the average daily population, in the 12-month pre-audit reporting period, to be 257 inmates and that the staffing plan was predicated on 257 inmates. The facility head discussed considerations for staffing and that they maintain at least a 1:75 staff-to-inmate ratio at all times and are mandated to do this via their contract with Oklahoma Department of Corrections. He feels the staffing levels are adequate in protecting inmates from sexual abuse. He added that all staff are cross-trained and can fill in security positions if needed. Specifically, all staff (e.g. maintenance, food service, case managers) receive the 120 hours of initial training; pre-service, in-service, and on-the-job. The composition of the population does not affect staffing since all dorms are in one building and the composition of the population does not change from one dorm to another. He was aware of higher risk areas in the facility such as the showers and commodes as well as the back of the dorms where there is less camera visibility. In regard to staffing in these areas, he discussed supervision rounds and counts in which these areas are covered. Video monitoring is also used to supplement staff supervision and, according to the facility head, is primarily used post-incident and for investigative purposes. There is camera coverage in all dorms and inmate common areas. The facility head reported that camera footage is recorded and retained for approximately 90 days.

115.213(b)
CoreCivic APS OP 030601 is the primary policy that outlines compliance with this standard. It addresses this provision regarding deviations from the staffing plan and asserts that staffing plan deviations shall be documented with notifications made using the 5-1B Notice to Administration form. Further, it charges the PREA compliance manager (PCM) with the responsibility of documenting on the 5-1B form and sending it to the PREA coordinator within seven calendar days, to include corrective action measures taken in response to the deviation.

The facility reported no deviations from their staffing plan, which was corroborated by the facility head who asserted that there has not been an instance, nor will there be an instance, in which they have gone below their minimum staffing level ratio of 1:75. Several things can ensure this does not happen; to include utilizing any non-security staff member (who have all received security training), the on-duty supervisor, or any administrator. He asserted that if necessary he would have to fill a security position himself to ensure the required ratio was met. They also have a procedure to request staff from another CoreCivic facility in the region, though, that has not been needed to date.

115.213(c)
CoreCivic APS OP 030601 is the primary policy that outlines compliance with this standard. It addresses this provision regarding annual reviews of the staffing plan; asserting that the PREA coordinator, facility head, and PREA compliance manager will assess the staffing plan annually by completing the 14-2 CC-I *Annual PREA Staffing Plan Assessment*. It further states that the annual assessment will be forwarded to the CoreCivic PREA coordinator, who will determine in conjunction with the respective CoreCivic vice president, whether there are adjustments needed pursuant to this provision. The 14-2 CC-I *Annual Staffing Plan Assessment* for the Carver Center was provided for auditor review. It was last completed on 10/24/17 and signed by the PREA coordinator and CoreCivic vice president of community

corrections. The first page of the assessment captures the gender of the population and custody level, a checklist for the four required elements of 115.231(a), two questions regarding the use and placement of video monitoring. The second page captures the review at the agency level, which provides for a description of policy or procedural changes, physical plant changes, video monitoring changes, and staffing changes and documentation from the vice president of community corrections of whether the changes are approved, denied, or not applicable. The last completed assessment documented that additional cameras were placed in two different areas.

**Corrective Action:**
None required.

## Standard 115.215: Limits to cross-gender viewing and searches

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.215 (a)**

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

**115.215 (b)**

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)
  ☐ Yes ☐ No ☒ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents) ☐ Yes ☐ No ☒ NA

**115.215 (c)**

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches of female residents?
  ☐ Yes ☐ No ☒ NA

**115.215 (d)**

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ No

**115.215 (e)**

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

**115.215 (f)**

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- *Pre-Audit Questionnaire* (PAQ)
- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- ODOC Search and Seizure Standards OP 040110 *(effective 7/29/14)*

- *Search Procedures* curriculum
- *Training Attendance Roster*

**Findings:**

115.215(a), (c)
On the PAQ, the facility reported they do not conduct cross-gender strip or body cavity searches and that no such searches occurred in the 12-month pre-audit reporting period. ODOC Search and Seizure Standards Policy OP 040110 *(p 4,5)* outlines procedures for inmate searches. It states that pat down, frisk, strip, and visual body cavity searches will be conducted by staff trained in conducting searches and by "gender specific staff…except in exigent circumstances or when performed by medical practitioners." The information gathered by the auditor, through discussion and interview of random staff, leadership, and inmates, affirmed that cross-gender strip or body cavity searches have not been conducted and that such searches are not in practice at the Carver Center. Therefore, there was no such documentation to review. However, in the event of an exigent circumstance in which a cross-gender strip or body cavity search is performed, ODOC OP 040110 mandates documentation of the search in accordance with ODOC Policy OP 050109 *Reporting of Incidents*.

115.215(b)
This provision has no bearing on compliance at this facility since it does not house female inmates.

115.215(d)
The facility has implemented policies and procedures that enable inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing them in a state of undress. Policy and procedure also requires staff of the opposite gender to announce their presence before entering an area where inmates may be in a state of undress. ODOC PREA Policy OP 030601 *(p 6)* cites this language.

This practice is well institutionalized at the Carver Center. The auditor noted that announcements of opposite gender staff were consistently made throughout the site review and onsite audit. This was also unequivocally corroborated by random staff and inmate interviews; all confirming that these announcements are made each time an opposite gender staff enters a dorm room or bathroom/shower area. They also confirmed that this has been a long-standing practice at the facility.

115.215(e)
ODOC Search and Seizure Standards Policy OP 040110 *(p 4)* cites this provision; prohibiting the search or physical examination of a transgender inmate for the sole purpose of determining their genital status. The facility reported that no such searches have occurred. The auditor learned, from the PREA compliance manager and other sources, that a transgender inmate had been admitted in the 12-month pre-audit reporting period. Discussions thereof were consistent with policy language and the prohibition of physical examination to determine genital status. Random staff consistently reported knowledge of the policy prohibiting this type of examination of transgender inmates. Through the time of the onsite audit, there were no transgender inmates at the facility.

115.215(f)

The PAQ indicated that 100% of security staff had received training on conducting cross-gender pat-down searches and searches of transgender and intersex inmates in a professional and respectful manner, consistent with security needs. ODOC Search and Seizure Standards Policy OP 040110 *(p 4)* addresses this provision. *Search Procedures* curriculum was also provided for review. The curriculum noted, specific to this facility, that cross-gender pat searches were to be conducted in exigent circumstances only. The curriculum defines exigent circumstances, includes scenarios of searching transgender inmates, and relays interpretive guidance from the Department of Justice prohibiting the "dual gender" pat search of transgender inmates. The auditor was also provided with a training roster documenting staff attendance for this *Search Procedures* training.

Random staff interviews revealed that staff had received this training and articulated that cross-gender pat searches are not conducted. Most recalled having watched a video that was also included in the pat search training. Upon inquiry, the auditor learned that it was the video offered and recommended by the PREA Resource Center; available on their website.

**Corrective Action:**
None required.

## Standard 115.216: Residents with disabilities and residents who are limited English proficient

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.216 (a)**

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect,

and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

**115.216 (b)**

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

**115.216 (c)**

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic PREA brochure (English and Spanish)
- ODOC *Inmates' Guide to Sexual Misconduct*
- Inmate Education Video: *What You Need To Know* (English and Spanish)
- ODOC *Zero Tolerance Acknowledgement* form (English and Spanish)

**Findings:**

115.216(a)
ODOC PREA Policy OP 030601 *(p 17)* states, "Every inmate will receive a written copy of the agency's orientation material in formats or through methods to ensure effective communication. Inmates whose primary language is not English will normally be provided a copy or translation of the orientation material in their own language. If literacy problems, intellectual disabilities/disabilities (visual/hearing impairments) exist, the inmate will be assisted in understanding the material."

As well, ODOC PREA Policy OP 030601 *(p 17)* states, "The agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under Title II of the Americans With Disabilities Act, 28 CFR 35.164."

The auditor learned that the agency and facility has well established procedures to ensure inmates with disabilities (including residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to benefit from the agency's PREA compliance efforts. Specifically, for inmates with hearing impairments, the inmate education video shown during orientation has subtitles. Additionally, the facility has the use of a TTY machine which is located in the administrative supply room. Staff members are charged with providing individual assistance to inmates with vision impairment or who have limited reading skills. The facility has conveyed the following practice to staff: "In the event that the facility receives an inmate who has a visual disability or is visually impaired we are required to read the PREA pamphlet, particularly the *Zero Tolerance Acknowledgement* to him and ensure he understands the facility policy on PREA."

The agency head spoke knowledgeably about procedures for inmates with disabilities and indicated that agency ensures an orientation in which critical information is effectively conveyed; so the inmate can comprehend information provided but also to ensure the facility can obtain critical information *from* the inmate. Further, he states that the agency has contracts for translation services at each facility and ensures those translation services are of high quality.

Given the facility setting; a halfway house that requires inmate employment, there are few inmates admitted that have psychiatric or intellectual disabilities. There were no such inmates at the facility during the onsite audit to interview. There were no inmates with visual impairments at the facility during the onsite audit to interview. The auditor interviewed an inmate who was reported to have limited reading and writing skills. This inmate corroborated the facility's stated practice and was able to articulate information provided to him regarding sexual abuse and sexual harassment. Additionally, discussions with intake staff confirmed their awareness to provide individual assistance to any inmate to ensure comprehension.

115.216(b)
ODOC PREA Policy OP 030601 *(p 17)* states, "Every inmate will receive a written copy of the agency's orientation material in formats or through methods to ensure effective communication. Inmates whose primary language is not English will normally be provided a copy or translation of the orientation material in their own language. If literacy problems, intellectual disabilities/disabilities (visual/hearing impairments) exist, the inmate will be assisted in understanding the material."

The auditor learned that the agency and facility has well established procedures to ensure inmates that are limited English proficient (LEP) can benefit equally from the agency's PREA compliance efforts. The facility reported that they use bilingual staff when possible and have AT&T translation services in which the inmate can select the language they speak. The primary non-English language encountered by the facility is Spanish. For Spanish speaking inmates, the facility offers the CoreCivic PREA brochure in Spanish, the inmate education video (titled: *What You Need To Know)* in Spanish, and the acknowledgement form in Spanish. These materials were provided for auditor review.

Staff that conduct the intakes were aware of these materials, knew where they were located, and provide them to inmates when needed. Some intake staff and random staff did not have awareness of the translation services or how to access them; generally reporting that they had not needed it. It is recommended that this area of training and awareness be enhanced. There were no LEP inmates at the facility during the onsite audit. None were reported by the facility and none were observed or discovered by the auditor while onsite.

The agency head spoke knowledgeably about procedures for inmates that are limited English proficient and indicated that the agency ensures an orientation in which critical information is effectively conveyed; so the inmate can comprehend information provided but also to ensure the facility can obtain critical information *from* the inmate. Further, he states that the agency has contracts for translation services at each facility and ensures those translation services are of high quality, they make efforts to recruit Spanish-speaking staff members, and the translation hotline is available 24 hours a day, every day.

115.216(c)
ODOC PREA Policy OP 030601 *(p 17)* asserts that no inmate interpreters are permitted outside of exigent circumstances. On the PAQ, the facility no instances in which an inmate interpreter was used. All random staff that were interviewed were aware that the use of inmate interpreters was prohibited,

particularly regarding an allegation of sexual abuse or sexual harassment. There were no LEP inmates at the facility during the onsite audit. None were reported by the facility and none were observed or discovered by the auditor while onsite.

**Corrective Action:**

None required.

## Standard 115.217: Hiring and promotion decisions

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.217 (a)**

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

**115.217 (b)**

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

**115.217 (c)**

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

**115.217 (d)**

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

**115.217 (e)**

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

**115.217 (f)**

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

**115.217 (g)**

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

**115.217 (h)**

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*
- ODOC Human Resources Policy OP 110235 *(effective 1/26/17)*
- ODOC Clearance form
- OSBI Clearance form
- *Self-Declaration of Sexual Abuse/Sexual Harassment* form
- Employee files

**Findings:**

The agency and facility exceed this standard for having demonstrated well established procedures for compliance; having clearly outlined and formalized all processes in policy and practice.

115.217(a), (d)
The agency and facility demonstrated well established procedures for prohibiting the hiring, promoting, or contracting with anyone who (1) has engaged in sexual abuse of inmates in an institutional setting; (2) has been convicted of engaging in sexual activity in the community facilitated by force, the threat of force, or coercion, or (3) has been civilly or administratively adjudicated to have engaged in such activity. ODOC Human Resources Policy OP 110235 *(p 29)* cites this language.

When interviewed, the human resources (HR) manager explained hiring practices as they relate to PREA and was very knowledgeable about the PREA Standards. The HR manager explained that ODOC conducts all criminal background checks for the facility upon her request and she receives a clearance form in return which indicates whether the subject has cleared the background check or not. Upon request by the auditor, the HR manager verified that the background check process through ODOC entails sending a release form and fingerprint cards to the Oklahoma State Bureau of Investigation (OSBI). Both a state and national (FBI) check is conducted. The HR manager explained that an applicant can begin employment prior to the receipt of background check results, though, this only entails the pre-service training. Reportedly, generally it takes two weeks to receive clearance from ODOC. There is no inmate contact during this phase of training and the training is conducted outside the

secure area in a separate building. This was also observed by the auditor, as there was a pre-service class in process while the auditor was onsite.

The auditor selected twelve employee files to review and verify the background check process. Each of the files contained documentation of clearance. Six of the files contained the ODOC clearance form, which indicated: 1) whether the applicant has or has not been cleared for employment; and 2) whether the results do or do not match the information provided by the applicant. Each of these six applicants had been cleared and each form indicated that the information matched what was provided by the applicant. The remaining six files were older files, dated prior to December 2017 and also contained background check clearance but on a different form, from the OSBI. It was noted that if there was any criminal record (which was the case in two of the files), then the record itself was attached for facility review. Regarding the two applicants that had a criminal record, neither had charges or convictions that are prohibited by this standard.

The Carver Center does not have contractors that have inmate contact. It was explained to the auditor that temporary contractors, such as plumbing, roofing, and electrical, are used when necessary but they do not have inmate contact and are not unsupervised while at the facility. Thus, criminal background checks were not conducted and, thus, no such records were reviewed.

115.217(b)
ODOC Human Resources Policy OP 110235 *(p 16)* asserts that incidents of sexual harassment will be considered by the appointing authority in deciding whether to hire or promote someone. The HR manager stated that incidents of sexual harassment would be considered prior to hire or promotion and the agency has implemented a *Self-Declaration of Sexual Abuse/Sexual Harassment* form which is completed by all employees and applicants. One the questions on the form inquires about whether the applicant has ever had a substantiated allegation of sexual harassment against them. The HR manager asserted that if there was an affirmative answer, the facility would attempt to contact with the respective employer and would make a case-by-case determination about hiring. Each of the employee files contained the completed self-declaration form.

115.217(c)
ODOC Personnel Policy OP 110210 *(p 9)* addresses this provision. As noted in provision (a), the facility has an established practice of performing criminal record background checks, which was verified by employee file review. Furthermore, it was also demonstrated that the facility makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The HR manager explained the agency's use of a *PREA Questionnaire For Prior Institutional Employers*. This two-page form consists of a release signed by the applicant, is sent to prior institutional employers, and has four questions to be completed by the prior employer. The form asks whether the applicant had any substantiated allegations of sexual abuse or sexual harassment and whether the applicant resigned during a pending investigation of sexual abuse or sexual harassment. Four of the employee files selected for review contained prior institutional employers. Two of the files did not contain the *PREA Questionnaire For Prior Institutional Employers*, but were hired by the agency that previously operated the facility. The other two files contained the completed *PREA Questionnaire For Prior Institutional Employers* form; verifying this practice.

115.217(e)

ODOC Personnel Policy OP 110210 *(p 4)* states that a background investigation will be conducted at least every five years for all employees.

The agency has a system in place for conducting criminal background records checks at least every five years of current employees who may have contact with inmates. The HR manager explained that she tracks this process by maintaining a spreadsheet which documents the dates that the checks are conducted and the date in which the employee is due again. The spreadsheet was provided for auditor review, though, the agency has not operated the facility for five years; therefore, no subsequent criminal background checks have been conducted yet or were found in employee files. The HR manager explained the procedure that will entail the employee signing another release form and a fingerprint card being submitted to ODOC.

115.217(f)
The agency uses the *Self-Declaration of Sexual Abuse/Sexual Harassment* form to ask all applicants and employees who may have contact with inmates about previous misconduct described in provision (a) of this standard. The form cites the three required questions about previous misconduct. The HR manager asserted that it is completed prior to hire as well as annually by current employees and is maintained in the personnel file. All 12 employee files reviewed by the auditor contained this completed form and this was also corroborated by random staff interviews. Employees sign this form each year as part of annual PREA training.

Furthermore, it was confirmed that the agency imposes upon employees a continuing affirmative duty to disclose any such misconduct. CoreCivic APS OP 030601 *(p 2)* asserts that the self-declaration form serves as verification of an employee's fulfillment of this continuing affirmative duty.

115.217(g), (h)
CoreCivic APS OP 030601 *(p 2)* states that, to the extent permitted by law, CoreCivic may decline to hire or promote or may terminate an employee based on material omissions of misconduct or for providing false information.

CoreCivic APS OP 030601 *(p 3)* cites this provision regarding the providing information on substantiated allegations.

The HR manager reported that no requests had been received, to her knowledge, inquiring about former facility employees being involved in substantiated allegations of sexual abuse. She stated that, if a signed release accompanied such a request, such information would be provided.

**Corrective Action:**
None required.

## Standard 115.218: Upgrades to facilities and technologies

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

**115.218 (b)**

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- CoreCivic APS OP 030601
- 7-1B *PREA Physical Plant Considerations* form

**Findings:**

115.218(a), (b)
CoreCivic APS OP 030601 *(p 18)* cites this standard stating that the agency will consider their ability to protect inmates from sexual abuse when making substantial modifications or expansions or when new monitoring technology is installed. This policy states that this documentation shall be documented on 7-1B *PREA Physical Plant Considerations* form. The 7-1B form was provided for review. It specifies the facility, project, date, and provides explanation and justification for both provisions of this standard. The auditor was provided with a completed example for verification of practice as well.

The Carver Center has made no substantial modifications or expansions but has updated video monitoring technology since the last PREA audit. The facility head confirmed there had been no expansions to the physical plant and no substantial modifications. He explained there had been minor changes made such as putting windows in doors. He also confirmed that the facility had installed additional cameras in areas that are not as heavily visited or harder to supervise, that it is mandatory for the dorm lights to remain on at all times in order to increase camera visibility, and that they have approximately 90 days of video retention. In addition, the Agency Head Designee Steven Conry articulated in a detailed manner the ways in which the agency considers their ability to protect inmates from sexual abuse regarding new facilities, modifications, expansions, and monitoring technology. He explained that the agency has a design team that is well exposed to the PREA Standards and implications thereof as it pertains to physical plant design. Mr. Conry as well as the PREA coordinator are involved in all builds, renovations, and expansions. He elaborated on the robust design process and its linkages to PREA; inmate safety, security, lines of sight. Specific to monitoring technology, he was again very knowledgeable about PREA implications and sexual safety, speaking about camera angles, lines of sight, and surveillance in specific areas such as near bathrooms. He explained that video monitoring near bathroom areas afford inmates adequate privacy while not blocking line of sight and not viewing inmates in a state of undress or using the toilet; to avoid cross-gender viewing by staff. He added that facilities have an ongoing ability to request additional cameras, though as part of the agency's capital expenditure process four to five facilities are chosen each year to receive a complete review of existing and needed monitoring technology.

CoreCivic exceeds this standard due to the robust and formalized systems that are place which are well institutionalized and well-articulated.

**Corrective Action:**
None required.

# RESPONSIVE PLANNING

## Standard 115.221: Evidence protocol and forensic medical examinations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.221 (a)**

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

**115.221 (b)**

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

**115.221 (c)**

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

**115.221 (d)**

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

**115.221 (e)**

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

**115.221 (f)**

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through

(e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

**115.221 (g)**

- Auditor is not required to audit this provision.

**115.221 (h)**

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*
- MOU with YWCA
- MOU with Oklahoma City Police Department
- Email communication with YWCA
- YWCA brochure
- First Responder cards

**Findings:**

115.221(a)
The facility conducts administrative investigations of sexual abuse and sexual harassment. Criminal allegations are referred to the ODOC who has the legal authority to conduct criminal investigations. Beginning on page 24, the ODOC PREA Policy OP 030601 outlines the investigation of sexual

“assaults.” This policy outlines protocol for recent sexual assaults (discovered within 120 of the incident) as well as sexual assaults that are discovered 120 hours or more after the incident. The uniform evidence protocol that is outlined in ODOC PREA Policy OP 030601 consists of significant detail regarding physical evidence on the alleged victim, the alleged abuser, and the crime scene; maximizing the potential for obtaining usable physical evidence.

Interviews with random staff revealed an awareness of the uniform evidence protocol and staff knowledge of protecting and preserving physical evidence. Each staff interviewed articulated their awareness to take actions to ensure that physical evidence was not destroyed. In addition, staff members had been issued a first responder card which they carried on them and many referenced it during their interview.

115.221(b)
The agency indicated that its uniform evidence protocol was adapted from or otherwise based on the most recent edition of the U.S. Department of Justice’s Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011. Upon review of the ODOC PREA Policy OP 030601 that outlines the protocol, there is sufficient technical detail to aid responders in obtaining usable physical evidence, to include timing considerations for the collection of evidence, to obtain a forensic exam from certified SAFE/SANE’s, consult medical and mental health staff, to have mental health available during interviews, etc.

115.221(c), (d)
The auditor was not provided policy language relevant to provision (c) but it was noted that CoreCivic APS OP 030601 *(p 12)* addresses provision (d).

It was demonstrated in practice, however, that the agency and facility offer all victims of sexual abuse access to forensic medical examinations, which are performed at the local hospital by certified Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). There were no forensic exams performed during the 12-month pre-audit reporting period. There was one allegation of inmate-on-inmate sexual abuse in which the inmate was transported to the ODOC “host” facility (prison) for medical assessment. However, the inmate became combative with nursing staff, was reportedly under the influence, and was unwilling to cooperate with the exam. The *PREA Response Checklist* documented that the inmate this and other incident reports documented the details of the incident. The auditor was provided an MOU between the YWCA and the Carver Center. It outlined emotional support services available to the facility but did not specify services for forensic examination. However, the auditor was also provided with email communication between the PREA compliance manager and the YWCA that verified the process by which they provide SAFE/SANE’s to the four local hospitals. It also outlined qualifications of YWCA personnel and confidentiality practices.

The agency and facility make available to the victim a victim advocate from the YWCA. This was outlined in the MOU provided. The auditor spoke with a senior officer at the YWCA that confirmed the organization’s services to the facility; forensic exam and emotional support. The senior officer was very familiar with PREA, the linkage between PREA and the YWCA, and expressed a desire to serve the facility’s population just as they would anyone in the community. Further, the senior officer expressed that, upon request, an advocate can come to the facility to provide advocacy services.

For the one allegation of sexual abuse during the 12-month pre-audit reporting period, the inmate was no longer at the facility for the auditor to interview regarding this provision.

115.221(e)
The auditor was not provided policy relevant to this provision. It was demonstrated in practice, however, that a victim advocate accompanies and support the victim through the forensic medical examination process and is offered emotional support, crisis intervention, information, and referrals. This is done through the YWCA. This provision also requires that an advocate accompany and support the alleged victim through investigatory interviews. The auditor did note that ODOC PREA Policy OP 030601 *(p 24)* states that investigators shall consult with and have available mental health support staff during interviews. There were no inmates at the facility who had alleged sexual abuse or who had received a forensic exam, for the auditor to interview. Thus, no such documentation existed either.

115.221(f)
In the event that the ODOC does not investigate an allegation of sexual abuse and it is referred to the Oklahoma City Police Department (OCPD), the auditor was provided with an MOU between the Carver Center and the OCPD. This MOU, signed by both parties in August 2017, states the OCPD agrees to use uniform practices for conducting investigations and obtaining physical evidence for criminal proceedings, using its current procedures for providing forensic examinations at no cost, and acknowledges that CoreCivic has an MOU with the YWCA to provide victim advocacy and emotional support for alleged victims of sexual abuse. While substantially meeting the requirement of this provision, this MOU could be enhanced to include victim advocacy and support through investigatory interviews.

115.221(g), (h)
These provisions have no bearing on compliance for this facility.

**Corrective Action:**
None required.

## Standard 115.222: Policies to ensure referrals of allegations for investigations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.222 (a)**

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

**115.222 (b)**

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

**115.222 (c)**

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

**115.222 (d)**

- Auditor is not required to audit this provision.

**115.222 (e)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- *Pre-Audit Questionnaire* (PAQ)
- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/24/16)*
- ODOC Investigations Policy OP 040117 *(effective 4/25/16)*

- MOU with Oklahoma City Police Department
- Incident Reports
- *Serious Incident Database Report*
- *Sexual Abuse Incident Review*
- Inmate Notification
- *Sexual Assault Report*
- *PREA Response Checklist*

**Findings:**

115.222(a), (b), (c)
ODOC Investigations Policy OP 040117 and ODOC PREA Policy OP 030601 outline the investigation of sexual abuse and sexual harassment. ODOC OP 040117 *(p 2)* states that all allegations of sexual abuse and sexual harassment including third party and anonymous reports "will be reviewed to determine if sufficient information exists to complete a formal investigation." CoreCivic APS OP 030601 *(p 12)* states, "The Facility Director shall ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse and sexual harassment."

The PAQ indicated there was one allegation during the 12-month pre-audit reporting period and it was referred for criminal investigation. During the pre-audit phase, this investigation was pending, though once onsite, the investigation had been closed and it was provided for auditor review. It was an inmate-on-inmate allegation and determined to be unsubstantiated. Incident reports, *Serious Incident Database Report, Sexual Abuse Incident Review*, inmate notification, *Sexual Assault Report*, and the *PREA Response Checklist* comprised the investigative documentation. The *PREA Response Checklist* documented that the allegation was reported on 1/25/18 and that notifications to the warden, medical, mental health, chief of security, PREA compliance manager, and ODOC were made the same day. The *Serious Incident Database Report* also documented that the incident was referred to internal affairs (ODOC) the same day. The full investigative report was not available as it was not provided to the facility. Discussion with the PREA compliance manager indicated that the facility does not receive the full investigative report but that the facility head has the ability to review the investigation in person, if the facility chooses to do so. The PREA compliance manager expressed that information is shared with the facility about the progress of the investigation. It was unclear the exact date in which the investigation was closed, though the auditor was able to deduce that it was after 2/6/18 and prior to 3/16/18; indicated by review of the facility's sexual abuse incident review documentation.

The agency head corroborated the agency's practice and expectations to ensure that all allegations of sexual abuse and sexual harassment are properly investigated; asserting that is "absolute" and the agency has a 5-1 reporting system they follow.

It is ideal and recommended that the facility receive the investigative report from the investigating entity or a summary of the investigation at minimum. Nevertheless, the auditor gathered evidence to support that the agency ensures an administrative or criminal investigation for all allegations of sexual abuse and sexual harassment.

Review of the CoreCivic website revealed CoreCivic PREA policies including one for community corrections centers, though, it was not the Agency Policy Supplement (APS) that was provided and used at the Carver Center. It was not demonstrated that this is an applicable policy for the Carver Center. Information about agency investigations did assert that all allegations are referred to the appropriate law enforcement agency for investigation and prosecution and also that, "Criminal allegations are generally referred via agreement to Local Law Enforcement Agencies or Investigating bodies under the authority of the Contracting Agency." Review of the ODOC agency website revealed the agency PREA policy which includes agency investigative procedures.

Investigative documentation reviewed by the auditor and discussion and interview of the designated facility investigator (PREA compliance manager) affirmed that allegations are referred to an agency with legal authority to conduct such investigations. In addition, the auditor spoke with an agent of the ODOC's investigative division who confirmed the process of receipt and investigation of sexual abuse and sexual harassment allegations. He asserted that when his division receives an allegation, they review and determine whether they will investigate or refer it back to the facility for investigation, which may happen if they feel the allegation does not meet criminal criteria.

In the event that the ODOC does not investigate an allegation of sexual abuse and it can be referred to the Oklahoma City Police Department (OCPD). The auditor was provided with an MOU between the Carver Center and the OCPD; signed by both parties in August 2017 and states that the OCPD agrees to conduct investigations of criminal activity including sexual abuse.

115.222(d), (e)
These provisions have no bearing on compliance for this facility.

**Corrective Action:**
None required.

# TRAINING AND EDUCATION

## Standard 115.231: Employee training

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.231 (a)**

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

**115.231 (b)**

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

**115.231 (c)**

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

**115.231 (d)**

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- PREA Training curriculum
- Training Acknowledgement forms
- PREA Training Acknowledgement forms
- Training Rosters

**Findings:**

115.231(a), (b), (c), (d)
ODOC PREA Policy OP 030601 *(p 11-12)* addresses PREA training for employees. All ten required training elements are cited in this policy and it asserts that the training applies to all staff including contract staff, volunteers, work crew supervisors, and interns. The PAQ indicated that the Carver Center currently has 44 staff that have received PREA training, which consists of all their staff members. The facility mandates that staff receive PREA training refreshers annually which is delivered as part of the facility's yearly in-service training.

Information compiled from random staff interviews indicated that the training is effective. Staff articulated all training elements well. Staff responses, knowledge, and awareness indicated an advanced knowledge of some of the training such as: LGBTI (lesbian, gay, bisexual, transgender, and intersex) inmates, LGBTI terminology, pat down searches and treatment of LGBTI inmates, and their response to an allegation. Staff appeared to have an understanding of the intent or purpose of PREA compliance efforts; the "why" behind the training.

Review of the curriculum indicated that it is tailored to the population of the facility; male inmates. Slide 7 discusses the differences in sexual abuse dynamics that staff can expect from male inmates as opposed to female inmates.

The auditor was provided all requested training records. Training records were provided for 12 auditor-selected staff members consisting of varying positions and ranks to include security staff, security staff supervisors, a case manager, a disciplinary officer, a food service worker, an employment specialist, and a transportation officer. There were at least two training acknowledgement forms in each file (with the exception of two, which contained only one). One form, titled *Training Acknowledgement* documented whether the employee attended PREA class or completed the online course, that the employee understood the training and their responsibility related thereto, and to seek clarification from the training director or PREA compliance manager if needed. Employees who had been there more than a year had one of these training acknowledgements for each year. The second training acknowledgement form, titles *PREA Training Acknowledgement,* had a summary of what the employee had heard, viewed, and received during the PREA training, accounted for whether the training was pre-service or annual training, and whether it was online training, specialized training, or instructor-led. Every selected employee had a signed and dated *PREA Training Acknowledgment*.

Staff articulation of the required training elements as well as the agency and facility training and training documentation exceed this standard.

**Corrective Action:**
None required.

## Standard 115.232: Volunteer and contractor training

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.232 (a)**

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

**115.232 (b)**

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

**115.232 (c)**

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- *PREA Contractor/Volunteer Training* handout
- ODOC *PREA Volunteer/Contractor Training Acknowledgement* forms

**Findings:**

115.232(a)
ODOC PREA Policy OP 030601 *(p 11-12)* addresses PREA training for employees. All ten required training elements are cited in this policy and it asserts that the training applies to all staff including contract staff, volunteers, work crew supervisors, and interns. The PAQ indicated that the Carver Center currently has 39 volunteers that have received PREA training. The auditor learned that facility has no contractors that have inmate contact.

The ODOC offers and requires that volunteers receive "badge" training. This is ODOC training that includes PREA and security-related training. Once completed, the volunteer receives a badge which allows entrance into the facility. Upon the initial visit to the facility, the volunteer receives additional *PREA Contractor/Volunteer Training*. A volunteer that was interviewed explained that she went through ODOC training and received her badge. It was a full day of training. She also reported another four hours of training at the facility in which she received the *PREA Contractor/Volunteer Training* and signed an acknowledgement form. Furthermore, she reported that she had been a volunteer since 2008. She spends a great deal of time volunteering at the Carver Center and other facilities as well. She has never had knowledge of sexual abuse or sexual harassment that has occurred at the facility.

115.232(b)
All volunteers are required to receive the same level and type of PREA training, which exceeds the requirements of this standard. The facility then ensures that volunteers receive facility-specific PREA

training. The volunteer that was interviewed corroborated training content; zero tolerance policy, dynamics of sexual abuse, and how/to whom to report such information.

115.232(c)
The facility provided volunteer and contractor training records. Records for seven auditor-selected volunteers and contractors were reviewed, which consisted of a *PREA Volunteer/Contractor Training Acknowledgement* form signed and dated by the volunteer or contractor. The form corresponds to a three-page handout titled *PREA Contractor/Volunteer Training.* The acknowledgement form lists the ten required training elements of training standard 115.231(a) and acknowledges that the volunteer or contractor has received the PREA training and understands the information. The three-page handout elaborates on the following: zero tolerance policy, inmate rights, reporting, common reactions of victims, dynamics of sexual abuse, first responder duties, and professional communication. The contractor training acknowledgement forms that were reviewed were for temporary contractors that do not have inmate contact, such as for plumbing and electrical services.

**Corrective Action:**
None required.

## Standard 115.233: Resident education

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.233 (a)**

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

**115.233 (b)**

- Does the agency provide refresher information whenever a resident is transferred to a different facility? ☒ Yes ☐ No

**115.233 (c)**

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

**115.233 (d)**

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

**115.233 (e)**

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic PREA Intake Pamphlet (English and Spanish)

- YWCA Pamphlet
- *Zero Tolerance Acknowledgement* form (English and Spanish)
- PREA Video: *What You Need To Know* (English and Spanish)
- *Orientation Booklet*

**Findings:**

115.233(a)
ODOC PREA Policy OP 030601 *(p 17-18)* addresses inmate education and orientation. Section A outlines verbal and written information. Section B outlines comprehensive education.

The agency and facility ensure that inmates receive information about the zero tolerance policy, how to report sexual abuse and sexual harassment, their rights to be free from sexual abuse and sexual harassment and retaliation, and agency response procedures. This occurs by providing: CoreCivic PREA pamphlet, ODOC PREA brochure, *Zero Tolerance Acknowledgement*, YWCA brochure, PREA video, and information in the inmate *Orientation Booklet*. The PAQ indicated that 789 inmates have received this information at intake during the 12-month pre-audit reporting period, which was reportedly 100% of the inmates admitted. The CoreCivic PREA Pamphlet contains information about how to report; listing the YWCA hotline, the agency hotline, and national hotline. It also outlines: what to do if an inmate is sexually abused, why to report sexual assault, what is sexual assault, and avoiding dangerous situations.

Shift supervisors are charged with conducting intakes at the Carver Center. Two shift supervisors were interviewed about providing PREA information during intake. One of them had not received all the training to conduct intakes and, therefore, had limited information on the process but shared part of the process. The other shift supervisor explained that the information is in a PREA packet and that the shift supervisor verbally informs them of the information therein; zero tolerance, how to report, PREA hotline. He also explained that after intake, all inmates go through orientation which is generally completed by a lieutenant. During orientation, the PREA Video is shown. The video used is titled *PREA: What You Need To Know*. Out of 21 inmates that were interviewed, 19 of them corroborated this to be practice and two inmates could not recall. All inmates, except one, reported seeing the PREA video and all inmates reported that they were provided this information right away at intake and that they saw the video at least within a few days of arriving.

115.233(b)
All inmates, regardless of where they transfer from, receive the same PREA information and the same orientation.

115.233(c)
As further elaborated in Standard 115.216, the facility provides inmate PREA education in formats accessible to all inmates, including those who are limited English proficient (LEP), deaf, visually impaired, otherwise disabled, as well as to inmates with limited reading skills. ODOC PREA Policy OP 030601 *(p 17)* states, “Every inmate will receive a written copy of the agency’s orientation material in formats or through methods to ensure effective communication. Inmates whose primary language is not English will normally be provided a copy or translation of the orientation material in their own language.

If literacy problems, intellectual disabilities/disabilities (visual/hearing impairments) exist, the inmate will be assisted in understanding the material."

The auditor learned that the agency and facility has well established procedures to ensure inmates with disabilities (including residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to benefit from the agency's PREA compliance efforts. Specifically, for inmates with hearing impairments, the inmate education video shown during orientation has subtitles and the facility has the use of a TTY machine. Staff members are charged with providing individual assistance to inmates with vision impairment or who have limited reading skills. The facility has conveyed the following practice to staff: "In the event that the facility receives an inmate who has a visual disability or is visually impaired we are required to read the PREA pamphlet, particularly the *Zero Tolerance Acknowledgement* to him and ensure he understands the facility policy on PREA."

Given the facility setting, there are few inmates admitted that have psychiatric or intellectual disabilities. There were no such inmates at the facility during the onsite audit to interview. There were no inmates with visual impairments at the facility during the onsite audit to interview. The auditor interviewed an inmate who was reported to have limited reading and writing skills. This inmate corroborated the facility's stated practice and was able to articulate information provided to him regarding sexual abuse and sexual harassment. Additionally, discussions with intake staff confirmed their awareness to provide individual assistance to any inmate to ensure comprehension.

The auditor learned that the facility also has well established procedures to ensure LEP inmates can benefit equally from the agency's PREA compliance efforts. They use bilingual staff when possible and have AT&T translation services in which the inmate can select the language they speak. For Spanish speaking inmates, the facility offers the CoreCivic PREA brochure in Spanish, the inmate education video (titled: *What You Need To Know)* in Spanish, and the zero tolerance acknowledgement form in Spanish. These materials were provided for auditor review.

Shift supervisors that conduct the intakes were aware of these materials, knew where they were located, and provide them when needed. Some intake staff and random staff did not have awareness of the translation services or how to access them; generally reporting that they had not needed it. It is recommended that this area of training and awareness be enhanced. There were no LEP inmates at the facility during the onsite audit. None were reported by the facility and none were observed or discovered by the auditor while onsite.

115.233(d)

ODOC PREA Policy OP 030601 *(p 18)* mandates that facility shall maintain documentation of inmate education, that is documented on the agency's zero tolerance acknowledgement form, and that is kept in section three of the inmate field file.

The facility maintains documentation of this inmate education by having them sign and date an ODOC *Zero Tolerance Acknowledgement* form which has a full page of PREA information and is signed and dated by both the inmate and staff member. Twenty-five auditor-selected inmate education records were reviewed to verify the practice of providing inmate education. The *Zero Tolerance Acknowledgement* form was in each file and signed by the inmate on the day of arrival.

115.233(e)
ODOC PREA Policy OP 030601 *(p 19)* charges the facility/district head with ensuring PREA information is continuously visible to inmates.

The auditor verified, by observation, that PREA posters are visible throughout the facility in all common areas and hallways and there is a plaque above every inmate phone that contains the PREA and YWCA hotline numbers. There is written PREA information available; in the inmate handbook and in the PREA and YWCA pamphlets. Thus, key information is continuously and readily available and visible to inmates.

**Corrective Action:**

None required.

## Standard 115.234: Specialized training: Investigations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.234 (a)**

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

**115.234 (b)**

- Does this specialized training include: Techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

**115.234 (c)**

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

**115.234 (d)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- Relias Training Description and Course Outline: *PREA Investigations Protocol*
- Relias training certificates of completion

**Findings:**

115.234(a), (b)

ODOC PREA Policy OP 030601 *(p 17)* states that specialized training is provided for employees that may respond to incidents of sexual assault and that the training may include (but is not limited to) crime scene management and elimination of contamination. It does not cite the required training elements. Further it asserts that for ODOC inspector general agents this training shall include conducting sexual abuse investigations in confinement settings.

The PAQ indicates that there is one investigator that has completed the required training. This is believed to reflect the person at the facility that has received specialized training pursuant to this standard. In fact, two facility staff members (one being the PREA compliance manager) had completed the specialized training. The two designated investigators have also received the general PREA training as required by this standard. They are the designated trainers for PREA. The auditor was provided with

documentation that agency, ODOC, as of May 2017 had 17 inspector general investigators that had received specialized training pursuant to this standard. The specialized training used by the facility and agency is from Relias. The Relias training description and course outline for PREA: Investigations Protocol was provided for review. The following topics were broken down in the outline: PREA Investigations and the Standards, Unique Nature of Sexual Abuse Investigations, General Investigative Considerations, and Investigative Protocols. Within the sub-headings of these topics were the required training elements of this standard.

The PREA compliance manager articulated in detail the process of conducting a sexual abuse or sexual harassment investigation. He elaborated on the required specialized training elements; was cognizant of techniques for interviewing victims, of the criteria for substantiating allegations and/or referring them for criminal investigation, etc.

115.234(c)

Certificates of completion were provided for the two designated facility investigators of the Relias training *PREA: Investigation Protocols*. The training was completed in September 2017.

**Corrective Action:**

None required.

## Standard 115.235: Specialized training: Medical and mental health care

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.235 (a)**

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

**115.235 (b)**

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

**115.235 (c)**

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☒ Yes ☐ No

**115.235 (d)**

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.] ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*

**Findings:**

ODOC PREA Policy OP 030601 *(p 17)* cites this standard, the required specialized training elements for medical and mental health staff, and that such training documentation shall be kept in the employee file.

The Carver Center, however, employs no medical or mental health staff. All such services are provided by the ODOC "host facility" which is also located in Oklahoma City. Inmates are transported there for all medical and mental health services.

**Corrective Action:**

None required.

# SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

## Standard 115.241: Screening for risk of victimization and abusiveness

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.241 (a)**

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No
- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

**115.241 (b)**

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility? ☒ Yes ☐ No

**115.241 (c)**

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

**115.241 (d)**

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☐ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? ☒ Yes ☐ No

**115.241 (e)**

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? ☒ Yes ☐ No

**115.241 (f)**

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? ☒ Yes ☐ No

**115.241 (g)**

- Does the facility reassess a resident's risk level when warranted due to a: Referral? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? ☒ Yes ☐ No

**115.241 (h)**

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

**115.241 (i)**

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- *Pre-Audit Questionnaire* (PAQ)
- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601*(effective 4/04/16)*

- 14-2 CC-B *Sexual Abuse Screening Tool*

**Findings:**

115.241(a), (b)
On the PAQ, the facility indicated that 789 inmates had been admitted and screened for sexual risk within the 12-month pre-audit reporting period. ODOC PREA Policy OP 030601 *(p 16)* contains a section titled *Screening/Assessment at Reception Centers*. This section does not cite the requirements of this provision but contains some relevant language pursuant to the screening of inmates for their risk of being sexually abused by other inmates or sexually abusive toward other inmates. CoreCivic APS OP 030601 provides more specific policy language relevant to this provision. APS OP 030601 *(p 5)* states that within 24 hours inmates will be screened using the CoreCivic 14-2 CC-B *Sexual Abuse Screening Tool.* Completed examples of the 14-2 CC-B *Sexual Abuse Screening Tool* were provided for auditor review pre-audit, which showed the date of the inmate's arrival and the date of the assessment. While onsite, the auditor requested completed screenings for all inmates that were selected for random interviews. These completed screenings were provided, showing the dates of the inmates' arrival and the date in which the screening was completed. In each case, the screening was completed either the same day of arrival or the following day. Assessments and reassessments were reviewed for 26 inmates.

The auditor observed the area in which the intakes and screenings are done and had formal and informal discussions with intake staff and others regarding the intake process. An interview with a staff member that completes the screenings asserted that these screenings are generally done within the first hour of an inmate's arrival. Similarly, random inmates that were interviewed recalled the screening occurred as well.

At Carver Center, case managers are charged with completing the *Sexual Abuse Screening Tool*. A discrepancy was noted with the ODOC OP 030601 *(p 20)* states, "These screenings and or evaluations are conducted by a qualified mental health professional." This and other language regarding assessing inmates sexual risk is not consistent with CoreCivic APS OP 030601 language that follows this standard more closely and is not entirely consistent with practice at the facility. It is recommended that this be rectified.

115.241(c)
CoreCivic's 14-2 CC-B *Sexual Abuse Screening Tool* is the objective screening instrument used by the facility. These completed forms were provided for review pre-audit and while onsite as a result of the auditor's random selection. The screening tool indicates yes/no responses to 14 questions in *Section I: Victimization History/Risk* and six questions in *Section II: Predatory History/Risk.* The tool indicates that an affirmative answer to either questions 1 or 2 means that the inmate is categorized as a "victim," an affirmative answer to four or more of the remaining questions 3-14 means that the inmate is categorized as a "potential victim," and if those do not apply "not applicable" is marked. In Section II, the tool indicates that an affirmative response to question 15 or 16 means the inmate is categorized as a "predator," an affirmative response to the remaining questions 17-19 means an inmate is categorized "potential predator," and if those do not apply "not applicable" is marked. Thus, the screening tool has a scoring mechanism and culminates in a determination of sexual risk. The tool also instructs staff to include a file review to supplement inmate responses. Therefore, the tool meets criteria to be considered

objective. It was noted and discussed with facility leadership, however, that the auditor recommends a formalized training process for staff who conduct the screenings, to ensure all staff are conducting an adequate file review to incorporate relevant information into the screening and that is done by all staff consistently.

115.241(d)
ODOC PREA Policy OP 030601 *(p 16)* contains a section titled *Screening/Assessment at Reception Centers*. This section does not cite the requirements of this provision but states, "This screening and/or evaluation include potential vulnerabilities or risks of being sexually abused by other inmates or being sexually abusive towards other inmates. These screenings and or evaluations are conducted by a qualified mental health professional." Page 20 states, "Risk factors for inmates included in this category are: younger, older, of small stature, first time inmates, mental or physically disabled, serving incarceration for a sexual related offense, prior institutional victimization, LGBTQI orientation, or perceived by other inmates as weak." In short, policy does not entirely encompass the requirements of this provision, though, this does not solely determine compliance since this provision does not have a policy requirement. Review of the 14-2 CC-B *Sexual Abuse Screening Tool* revealed that all required screening factors of this provision are captured in the tool. Completed screenings were provided for review and verified as an institutionalized practice.

As a recommendation, the auditor noted and discussed with the facility, implementation of a mechanism to specifically identify transgender and intersex inmates so the facility can better demonstrate required placement, programming, and reassessments. Although the risk screening tool inquires about an inmate's LGBTI status, there is no prompt to specifically indicate when the inmate's status is transgender or intersex and then trigger placement and programming decisions thereof. Currently, the facility is relying on this happening informally. It was also noted that the PREA compliance manager felt there still needed to be additional emphasis on staff training and awareness of transgender/intersex inmates and its PREA implications.

The fact that all required screening factors are considered in practice and because interviews of staff that complete the screening tool affirmed the consideration of these factors, the agency and facility has met this provision.

115.241(e)
There is no policy language relevant to this provision, though, by review of the 14-2 CC-B *Sexual Abuse Screening Tool*, the auditor verified that the agency considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive. Section II of the screening tool includes scored items that consider the required elements of this provision. Completed screenings were provided and verified as an institutional practice. Staff that complete the screening tool affirmed the consideration of these factors as well. Further, it was explained that file review was completed as part of the screening process, looking for prior institutional violence or other details of the inmate's history that were relevant to these factors. It was noted, however, there was some inconsistency in whether, or how, staff consider or conduct a file review as part of the screening. It is recommended this be formalized or specifically outlined so that all staff that conduct screenings complete them in the same manner and that it entails a file review.

115.241(f)

CoreCivic APS OP 030601 *(p 5-6)* cites this provision; mandating inmate reassessment within 30 days of arrival. CoreCivic APS OP 030601 asserts that this reassessment will be accomplished using the 14-2 CC-B *Sexual Abuse Screening Tool* to include any additional relevant information received by the facility since the initial 14-2 CC-B *Sexual Abuse Screening Tool* was completed.

Case managers are charged with conducting the reassessments. Discussion with two case managers regarding the reassessment process expressed that the expectation was for the reassessments to be completed at 25 days using the *Sexual Abuse Screening Tool*. One case manager explained that it is done with a face-to-face meeting with the inmate in which the case manager completes the screening form and looks for anything that has changed since the initial screening. Once the reassessment screening is complete, it is put in a designated locked box. The PREA compliance manager has the key to the box and picks them up daily to review and retain them. The PREA compliance manager maintains a tracking system to denote when an inmate's initial screening is completed and the number of days since arrival and when the reassessment screening due. An inmate's name remains on the list until the reassessment has been completed.

Reassessments were provided pre-audit and onsite as a result of auditor selection. Indicated at the top of the *Sexual Abuse Screening Tool* are checkboxes for: Initial, 30 Day Reassessment, or New Information. Therefore, the reader can easily decipher the reason for its completion. The screening form captures any differences between the inmate interview and the staff member's file review; the last question is, "Are there discrepancies between the interview and the file review?" The auditor requested both the initial and all reassessment forms for all random inmates which were selected for interview. The assessment and reassessment forms provided pre-audit and onsite verified that reassessments are completed according to OP 030601 APS; within 30 days of inmates' arrival. Assessments and reassessments were reviewed for 26 inmates.

Of the 21 inmates that were interviewed, nine had been at the facility less than a month. Therefore, their 30-day reassessment was not yet due. The remaining 12 inmates did not recall having been asked these screening questions again after arrival.

**Corrective Action:**
None required.

## Standard 115.242: Use of screening information

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.242 (a)**

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No

**115.242 (b)**

- Does the agency make individualized determinations about how to ensure the safety of each resident? ☒ Yes ☐ No

**115.242 (c)**

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

**115.242 (d)**

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

**115.242 (e)**

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

**115.242 (f)**

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*
- ODOC *Cell Assessment Form*
- *PREA Bunk Assignment Instructions*
- *Sexual Abuse Screening Tool*

**Findings:**

115.242(a), (b)
ODOC PREA Policy OP 030601 *(p 16)* states that the agency shall use the information from the risk screening tool in accordance with Policy OP 030102 using Attachment A, *Cell Assessment Form,* to

inform decisions about inmate housing, work, program, and education assignments. The ODOC OP 030601 policy language asserts that this is done with the goal of keeping inmates who are at risk of sexual victimization separate from those at risk of being sexually abusive and that individualized determinations are made about how to best ensure inmate safety.

Several staff members provided information about how the risk screening information was used to keep inmates safe from sexual abuse. This appeared to be a well-established system as it was well articulated by supervisors and leadership alike. The PREA compliance manager expressed that the system in place is effective. The facility has identified certain inmate bunks in each dorm where vulnerable inmates will be housed if their risk screening categorizes them as a victim or potential victim. These bunks are closest to the dorm entrance and closest to the cameras in order to allow for better monitoring. The PREA compliance manager maintains a secure spreadsheet that identifies these bunks and the inmates that are assigned to them. The auditor was provided with *PREA Bunk Instructions* which was in memo format from the PREA compliance manager to the shift supervisors and case managers. It outlined the notification process required when an inmate is identified to be at risk as well as the procedures for assigning a "PREA bunk."

Shift supervisors are responsible for completing the initial risk screening upon intake using the *Sexual Abuse Screening Tool* (as further analyzed in the previous Standard 115.241). Interviews with three shift supervisors indicated familiarity with assigning "PREA bunks" pursuant to the risk screening. One shift supervisor explained that the risk screening is completed and if it depicts affirmative answers on a certain number of questions then the inmate is categorized as a victim or potential victim. For any such inmate, the shift supervisor references the secure spreadsheet to see what "PREA bunks" are open. The shift supervisor was aware that the placement, closer to the camera and dorm entrance, allowed for increased supervision. All shift supervisors reported they had no knowledge of inmates at the facility that were categorized as predators or potential predators.

Case managers complete subsequent screenings using the *Sexual Abuse Screening Tool*; reassessments of sexual risk. The case manager interviewed was also aware of the assignment of "PREA bunks" if indicated by the risk screening. Further, the case manager if there was a change on the risk screening, from unrestricted to vulnerable, the PREA compliance manager and chief of security would be informed and would facilitate a bunk move to one of the designated "PREA bunks."

The system in place is formalized and well institutionalized, well-articulated, and well documented; exceeding this standard.

115.242(c), (d), (e)

ODOC PREA Policy OP 030601 *(p 17)* cites these provisions regarding case-by-case placement of transgender and intersex inmates. CoreCivic APS 030601 *(p 7)* addresses housing and placement of LGBTI and gender nonconforming inmates and also cites this provision. The ODOC makes the decisions regarding (male or female) facility placement while CoreCivic and the facility make the inter-facility decisions.

The PREA compliance manager was knowledgeable about the requirements of placement and programming for transgender and intersex inmates as it relates to the PREA Standards. At the Carver Center, procedures have been established to allow for the use of a single room in building B for housing a transgender or intersex inmate. This would ensure the inmates safety and the opportunity for showering separately. The auditor observed this building and designated room during the site review.

The auditor learned that the facility had a transgender inmate admitted during the previous 12 months and that they had begun putting these procedures in place, but the inmate was quickly transferred because of unrelated matters. There were no transgender or intersex inmates at the facility during the onsite audit. The PREA compliance manager felt there still needed to be additional emphasis on staff training and awareness of transgender/intersex inmates and its PREA implications.

The auditor noted, and discussed with the facility, a recommendation to implement a mechanism to specifically identify transgender and intersex inmates so the facility can better demonstrate required placement, programming, and reassessments. Although the risk screening tool inquires about an inmate's LGBTI status, there is no procedure to indicate if the inmate's status is transgender or intersex and then trigger placement and programming decisions thereof. Currently, the facility is relying on this happening informally.

115.242(f)

ODOC PREA Policy OP 030601 *(p 17)* cites this provision prohibiting the placement of LGBTI inmates in dedicated units or wings. The auditor verified by observation, through the site review, that there were no such dedicated units or wings. The agency and facility were under no consent decree or the like.

**Corrective Action:**

None required.

# REPORTING

## Standard 115.251: Resident reporting

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.251 (a)**

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

**115.251 (b)**

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

**115.251 (c)**

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

**115.251 (d)**

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*
- YWCA MOU
- *Zero Tolerance Acknowledgement* Form
- *Inmates' Guide to Sexual Misconduct brochure*
- *Orientation Booklet*
- *Orientation Checklist*
- PREA Reporting Information poster

**Findings:**

115.251(a)

The agency provides multiple methods for reporting inmate sexual abuse and sexual harassment, retaliation, and staff neglect or violation of responsibilities that may have contributed to such incidents. ODOC PREA Policy OP 030601 cites the following ways to report: staff member, third party, hotline, sick call, request to staff, anonymous, ODOC Office of Inspector General, or Oklahoma State Bureau of Investigation (OSBI).

Twelve random staff and 21 random inmate interviews indicated an awareness of multiple reporting methods. Every one of these interviewees articulated multiple methods. PREA signs with the hotline number posted around the facility in all common areas and dorms. Plaques with the PREA hotline and YWCA hotline were above every inmate phone. Sick call and request to staff slip were observed in the dorms; each having a locked box for submission.

Additionally, the *Zero Tolerance Acknowledgement* form that is signed upon intake by the inmate lists the multiple reporting methods.

It should be noted that the YWCA is not a method of external reporting but only for outside emotional support services. The YWCA MOU was provided as supporting documentation for this standard and did not include language about the YWCA forwarding reports of sexual abuse back to the agency for investigation, which is required by this provision. Additionally, the conversation with the representative from the YWCA confirmed that they are bound by confidentiality that prohibits them from forwarding inmate reports.

115.251(b)
The ODOC PREA Policy OP 030601 lists two external entities for reporting sexual abuse and sexual harassment; the ODOC Office of the Inspector General (OIG) and the OSBI. The ODOC OIG may or may not be considered external to the agency, as required by this provision. It is external to the facility and external to CoreCivic, though, in some respects the ODOC also acts as the “agency” as it relates to the PREA Standards. CoreCivic APS OP 030601 *(p 8)* lists the agency PREA coordinator address as a method of external report, however, that is still internal to the agency. The PREA hotline goes to the ODOC OIG. To report via the hotline, the reporting party leaves a recorded message which is checked every day by the OIG. The PREA compliance manager explained that he conducts tests of the hotline once a month to ensure it is working properly.

All inmates interviewed listed several reporting avenues; one being the PREA hotline. They did not specifically articulate that is was a method of report that is external to the agency. They all were aware of the PREA hotline but did not know where the hotline went. Nonetheless they were abundantly aware of the hotline.

The *Zero Tolerance Acknowledgement* form that is signed upon intake by the inmate lists the multiple reporting methods. That information includes an address for the OIG and for the OSBI. The inmate does not retain this document for future reference and use, but these addresses are also found on the *PREA Reporting Information* poster. This poster lists all reporting methods. At the bottom are addresses for OIG and then OSBI. Under OSBI is an asterisk that designates this to be “not part of CoreCivic or the Oklahoma Department of Corrections.” The *Inmates’ Guide to Sexual Misconduct* brochure that is provided to all inmates upon intake provides the address for the OIG, though the only truly external entity is the OSBI.

115.251(c)
ODOC PREA Policy OP 030601 *(p 17)* mandates the reporting of reports pursuant to this provision and that verbal reports shall be documented on the *Incident/Staff Report* form. CoreCivic APS OP 030601 *(p 9)* addresses employee reporting; mandating that all employees must take seriously and document all reports of sexual abuse and sexual harassment including verbal, third-party, and anonymous reports treating all as if they were credible. CoreCivic APS OP 030601 also states that failing to report such information may result in disciplinary action.

Twelve random staff interviews revealed an across-the-board understanding of their reporting requirements under this provision. This information is well covered in staff PREA training, which was reviewed in the training curriculum and conveyed in random staff interviews. In addition, many random inmates interviewed conveyed they had trust in reporting to staff members and they were confident that action would be taken.

115.251(d)
ODOC PREA Policy OP 030601 *(p 20)* lists methods by which staff can privately report sexual abuse or sexual harassment. These methods consisted of: OIG, PREA hotline, and an email address (preareport@doc.state.ok.us). Staff interviewed felt they could report privately to their supervisor or any superior.

In addition, the staff training acknowledgement form they sign at pre-service and annually also lists the private reporting methods that are cited in ODOC PREA Policy.

**Corrective Action:**
None required.

## Standard 115.252: Exhaustion of administrative remedies

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.252 (a)**

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☒ Yes ☐ No ☐ NA

**115.252 (b)**

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**115.252 (c)**

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**115.252 (d)**

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)] , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**115.252 (e)**

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
  ☐ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

**115.252 (f)**

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**115.252 (g)**

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- ODOC Grievance Policy OP 090124 *(effective 7/19/06)*
- *Inmate/Offender Grievance* form
- Posted grievance policy on bulletin boards
- *Orientation Booklet*

**Findings:**

115.252(a), (b)
The agency is not exempt from this standard as it does have administrative procedures to address inmate grievances regarding sexual abuse. ODOC Grievance Policy OP 090124 *(p 15)* states that inmates are not subject to informal resolution or a time limit when the complaint is of a sensitive nature and cites each element of Provision (b). It specifies the use of the *Inmate/Offender Grievance* form for submitting such complaints. The auditor reviewed the grievance form, locations in the facility where the grievance forms were accessible to inmates, and the locked grievance boxes for submitting them.

All grievances are numbered, given a grievance code, and date when the response is due. This is indicated at the top of the grievance form. The original grievance is kept in the inmate file and a copy of the grievance is given to the inmate. This is indicated at the bottom of the form.

Random inmate interviews indicated that inmates were well informed of multiple reporting methods. Reporting via grievance was not a method of report that was expressed by any inmate. The auditor gathered there to be many other effective means of reporting which were articulated by inmates. Nonetheless, the entire grievance policy was posted on the bulletin boards in each dorm. Grievance information was also found in the *Orientation Booklet (p 16),* though, this was abbreviated information and did not cover sexual abuse or sexual harassment grievances. Though, the auditor has received evidence of substantial compliance, it is recommended that the *Orientation Booklet* reflect accurate information about sexual abuse and sexual harassment grievances or refer them to the posted grievance policy for "emergency" and "sensitive" grievances.

115.252(c)
ODOC Grievance Policy OP 090124 *(p 15)* asserts that an inmate may submit a grievance of a sensitive nature, or one against a staff member, directly to the reviewing authority. The policy directs the inmate to write "sensitive" on the top of the grievance.

The grievance policy was posted on the bulletin boards in each dorm, but it is recommended that the grievance information in the *Orientation Booklet* be consistent with the policy language regarding the submission of sexual abuse grievances pursuant to this provision.

115.252(d), (f)
ODOC Grievance Policy OP 090124 assumes all sexual abuse or sexual harassment grievances to be an “emergency” or “sensitive,” which the inmate should indicate on the grievance. Page 16 mandates that for any grievance marked as “emergency” or “sensitive,” the reviewing authority has 24 hours to determine whether it is sensitive or urgent. If so, the policy mandates an expedited review and response to the inmate within 48 hours. The inmate has a right to appeal by which the policy further states that the agency will provide an expedited response to any verified “emergency” or “sensitive” grievances within 72 hours of receipt of such grievance. If it is determined not be emergent, policy mandates the inmate be provided written notification that it is not emergent and that the standard grievance procedure will be followed.

The Carver Center reported zero sexual abuse grievances during the 12-month pre-audit reporting period.

115.252(e)
ODOC Grievance Policy OP 090124 *(p 16)* cites the verbiage of this provision regarding assistance for filing a grievance alleging sexual abuse.

The Carver Center reported zero grievances alleging sexual abuse filed by residents in which the resident declined third-party assistance.

115.252(g)
ODOC Grievance Policy OP 090124 *(p 17)* outlines the determination for abuse of the grievance system. It is not specific to this standard but asserts that the reviewing authority determines whether abuse of the system has occurred and may restrict the inmate’s use of the system. It then further outlines parameters of the restrictions and mandates notification to the inmate when this occurs citing the reasons for it.

The auditor also noted that the *Orientation Booklet*, in the PREA section, states, “Deliberate false allegations can result in disciplinary action and/or prosecution.”

The Carver Center reported zero grievances alleging sexual abuse that resulted in disciplinary action for having filed the grievance in bad faith.

**Corrective Action:**
None required.

## Standard 115.253: Resident access to outside confidential support services

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers,

including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

**115.253 (b)**

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

**115.253 (c)**

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- YWCA brochure
- ODOC *Inmates' Guide to Sexual Misconduct* brochure
- *Prison Rape Elimination Act (PREA) Reporting Information* poster
- CoreCivic PREA brochure

**Findings:**

115.253(a), (c)
The agency and facility provide inmates with access to outside emotional support services through the YWCA. Policy was not provided that mandates the giving of mailing address or phone numbers to outside emotional support, though, it does address agency efforts to obtain these services through an MOU. An MOU has been established between the Carver Center and the YWCA, which was provided for review. The MOU outlines services for emotional support pursuant to this standard. Additionally, the auditor spoke with a YWCA representative who was familiar with PREA and verified the existence of the MOU and services.

There is a plaque above every inmate phone which contains the YWCA hotline number. Inmates are given a YWCA brochure during orientation, which contains information about services available, hotline number, and mailing address. The hotline to the YWCA is also in the *Inmates' Guide to Sexual Misconduct* brochure.

There were no inmates who had reported sexual abuse at the facility during the onsite audit. In general, through random inmate interviews, inmates were not aware of outside emotional support. Most inmates reported that it may have been in the written materials or gone over verbally but since they hadn't needed that type of information they were not directly aware of it. Despite most inmates not being directly aware of outside emotional support services, sufficient evidence supported that inmates were provided with this information which was also verified by the auditor upon review of intake packet, discussion and interview with the PREA compliance manager, and intake staff.

115.253(b)
The MOU with the YWCA specifies that the facility shall inform inmates of the extent to which communications with them will be monitored and the extent to which reports of abuse will be forwarded to authorities. The auditor was provided with no evidence to support that this occurs in practice. Inmates were not aware of the availability or accessibility of outside emotional support services. Most inmates reported that it may have in the written materials or gone over verbally but since they hadn't needed that type of information they were not directly aware of it. Posted around the facility is a *PREA Reporting Information* flyer which lists methods of report with phone numbers and mailing addresses, one of which is the YWCA. No information regarding the reporting or monitoring of such calls is included.

**Corrective Action:**

1. The facility shall inform inmates of the extent to which communications with the YWCA will be monitored and the extent to which reports of abuse will be forwarded to authorities. The auditor ascertained that the YWCA will not forward reports of abuse to authorities, however, inmates are not informed of this. In addition, it shall be made clear to inmates whether communications (phone or otherwise) with the YWCA are monitored by the facility.

**Update on Corrective Action:**

1. After consultation between the auditor, PREA coordinator, and PREA compliance manager, the facility amended their *Prison Rape Elimination Act (PREA) Reporting Information* flyer (provided 5/31/18) to include the following verbiage directly below the YWCA listing and phone number: "Telephone lines at the Carver Center are not monitored or recorded. Reports of allegations to the DOC PREA Hotline will be forwarded to the Carver Center and to law

enforcement for investigation. Calls to the YWCA Hotline for emotional support are confidential and will not be reported to the Carver Center or Oklahoma DOC." Flyers with the new verbiage has been posted around the facility in place of the older version. This corrective action is satisfied.

## Standard 115.254: Third-party reporting

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.254 (a)**

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- ODOC website
- CoreCivic website

**Findings:**

115.254(a)
ODOC PREA Policy OP 030601 states in two places that third party reports shall be accepted, but does not address establishing a method or address its public distribution. CoreCivic APS OP 030601 *(p 9)* cites this provision and states that this information will be posted on the agency website.

The agency has established a method to receive third-party reports of sexual abuse and sexual harassment and publicly distributes the information on how to report sexual abuse and sexual harassment.

CoreCivic website offers ample information about PREA, part of which is regarding third-party reporting. Options listed are: send letter to warden, CoreCivic's Ethics and Compliance Helpline at 1-866-757-4448 or online, agency PREA coordinator number and address.

ODOC website also has PREA information to include third party reporting. Options listed are: send an email to preareport@doc.ok.gov, call the PREA Reporting line at 1(855) 871-4139, call the ODOC Fugitive Apprehension and Investigations at (405) 425-2571, verbally report to a DOC facility administrator or staff member *ODOC Facility Information*, phone number and address of the agency PREA coordinator.

**Corrective Action:**

None required.

# OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

## Standard 115.261: Staff and agency reporting duties

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.261 (a)**

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

**115.261 (b)**

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

**115.261 (c)**

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

**115.261 (d)**

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

**115.261 (e)**

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*

**Findings:**

115.261(a)

ODOC PREA Policy OP 030601 *(p 19)* cites this provision requiring all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Each of the 12 random staff interviewed articulated this requirement and many reported awareness of disciplinary action for failure to follow the reporting requirements.

115.261(b)
ODOC PREA Policy OP 030601 *(p 10)* cites this provision prohibiting staff from revealing information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Three random staff specifically articulated the expectation of not telling other staff members or inmates about information related to an incident of sexual abuse, though, this question was not directly asked. Review of the staff training curriculum revealed training content about this provision.

115.261(c)
ODOC PREA Policy OP 030601 addresses this provision, although, the Carver Center does not employ medical and mental health staff. This provision is not applicable.

115.261(d)
ODOC PREA Policy OP 030601 addresses this provision, although, the Carver Center does not admit inmates under the age of 18. This provision is not applicable.

115.261(e)
The facility reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. ODOC PREA Policy OP 030601 *(p 19)* states that all allegations shall be reported to the OIG, although, in practice all reports of sexual abuse are forwarded to the OIG. Sexual harassment reports are forwarded to the PREA compliance manager for investigation and to facility leadership.

This practice was articulated by the PREA compliance manager; the designated facility investigator, as well as the by the facility head. The facility head elaborated on the process; that notification of a PREA report is done using a "PREA Community" email distribution list and that there are two notification tracks; one to ODOC and one to CoreCivic. Included in that process is always the respective investigator.

**Corrective Action:**

None required.

## Standard 115.262: Agency protection duties

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.262 (a)**

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*

**Findings:**

115.262(a)
ODOC PREA Policy OP 030601 *(p 5)* cites this standard asserting that immediate action will be taken to protect an inmate that is imminent danger of sexual abuse. CoreCivic APS OP 030601 *(p 19)* cites this standard asserting that immediate action will be taken to protect an inmate that is imminent danger of sexual abuse.

All 12 random staff interviewed, as well as the agency head and facility head, explained they would take immediate action if they learned an inmate was subject to a substantial risk of imminent sexual abuse. Random staff reported they would keep the inmate separate from other inmates and ensure their safety until further direction from supervisors was provided. The facility head explained that the inmate would be kept separate from others and that a prompt facility transfer could be arranged, if needed.

There were no instances of an inmate being at risk of imminent sexual abuse during the reporting period.

**Corrective Action:**
None required.

## Standard 115.263: Reporting to other confinement facilities

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.263 (a)**

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

**115.263 (b)**

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

**115.263 (c)**

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

**115.263 (d)**

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*

**Findings:**

115.263(a), (b), (c)

ODOC PREA Policy OP 030601 *(p 23)* cites the language of this provision regarding reporting sexual abuser to other confinement facilities.

The PAQ indicated there was one allegation during the 12-month pre-audit period in which an inmate alleged sexual abuse while confined at another confinement facility. However, the auditor was not provided with documentation demonstrating compliance with this standard; notification to the other confinement facility within 72 hours of receiving the allegation.

115.263(d)
ODOC PREA Policy OP 030601 *(p 23)* cites the language of this provision asserting that any allegation, received from another facility, of sexual abuse that occurred at the Carver Center, will be referred immediately to the OIG for investigation.

The agency head designee asserted that such a notification would result in an investigation just as any other allegation. The facility head corroborated that receiving such a notification would enact PREA protocols and that he had no knowledge of such notifications at the Carver Center (It was noted that he was acting facility head and had been for only two weeks).

**Corrective Action:**

1. The facility shall provide documentation demonstrating that the allegation received, of abuse at another confinement facility, was forwarded to that facility's director in accordance with this standard.

**Update on Corrective Action:**

1. Documentation demonstrating compliance with this standard was provided via email 6/12/18. *Serious Incident Database Report* and *Incident Notification Checklist* was provided which documented the allegation and the facility's response. The documentation showed that the inmate reported sexual abuse to the Carver Center upon intake on 3/16/18. The PREA compliance manager spoke with the inmate on 3/20/18 and documented that the warden of the other facility was notified as well as the facility's contract monitor and the ODOC's OIG. This documentation affirms that required notification was made and it was made within the 72-hour timeframe. This corrective action is satisfied.

## Standard 115.264: Staff first responder duties

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.264 (a)**

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
  ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

**115.264 (b)**

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- *Pre-Audit Questionnaire* (PAQ)
- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*
- *PREA Response Checklist*
- Investigative records

**Findings:**

115.264(a), (b)
ODOC PREA Policy OP 030601 *(p 23)* cites the language of this standard, outlining first responder duties. CoreCivic APS OP 030601 *(p 10)* cites the same language.

The PAQ indicated there was one allegation of sexual abuse during the pre-audit reporting period in which the first security staff member separated the alleged victim and abuser. The PAQ also indicated there were no allegations where staff were notified within a time period that still allowed for the collection of physical evidence. This was confirmed by a review of the investigative documentation. The *PREA Response Checklist* documents whether the first responder separated the alleged victim and abuser. The checklist in this case indicated they were separated. It also documents whether notification was within time period that allowed for collection of physical evidence. The checklist indicated it was not. If there is an affirmative response, the checklist then prompts the documentation of whether staff protected the crime scene, requested the victim take no actions that could destroy evidence, and ensured the abuser could take no actions to destroy evidence.

During the pre-audit reporting period, there were no non-security staff first responders.

The inmate involved in the allegation of sexual abuse was no longer at the facility during the onsite audit. Therefore, he was not interviewed.

**Corrective Action:**

None required.

## Standard 115.265: Coordinated response

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.265 (a)**

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does*

*not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*
- *PREA Response Checklist*
- SART Memo

**Findings:**

115.265(a)
ODOC PREA Policy OP 030601 *(p 20)* outlines initial response and separation procedures; first responder duties, completion of the *Serious Incident Database Report, Sexual Assault Report, and PREA Response Checklist*, placement of the alleged victim and abuser, and immediate medical services. CoreCivic APS OP 030601 *(p 10)* further outlines the responsibilities of the SART (Sexual Assault Response Team) which is defined in the policy as a team of four or more individuals having a primary role in responding to sexual abuse incidents, victim assessment and support needs. CoreCivic APS OP 030601 *(p 10)* expounds on SART team responsibilities and SART member responsibilities. The auditor was provided with a memo listing the staff members that comprise the SART at the Carver Center.

The *PREA Response Checklist* is the agency and facility's method of documenting the actions of the SART team and coordinated response. The completed *PREA Response Checklist* was reviewed and maintained in the investigative file for the allegation of sexual abuse that occurred during the pre-audit reporting period. Interviews with the PREA compliance manager and other leadership and staff indicated an awareness of the specified coordinated response. The facility head was not directly familiar with the coordinated response as outlined in policy, or did not articulate such in his interview, though he expressed knowledge of response to sexual abuse.

**Corrective Action:**

None required.

## Standard 115.266: Preservation of ability to protect residents from contact with abusers

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.266 (a)**

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

**115.266 (b)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- *Pre-Audit Questionnaire* (PAQ)
- CoreCivic APS OP 030601 *(effective 4/04/16)*

**Findings:**

115.266(a), (b)
CoreCivic APS OP 030601*(p 13-14)* addresses this standard regarding collective bargaining agreements entered by the agency; ensuring the agency is not limited in the removal of staff members involved in inmate sexual abuse.

The Carver Center has not entered into collective bargaining agreements, though the CoreCivic agency head designee expressed knowledge and practice of these requirements from an agency level and as it relates to other facilities. In fact, the agency exceeds this standard as articulated by the agency head designee. It was explained that himself, the PREA coordinator, and other key players including the PREA team is part of the negotiating team when it comes to collective bargaining agreements. Further he explained that the PREA coordinator looks for PREA implications ensuring compliance with this standard and that the human resources lead labor negotiator has also been trained in PREA and requirements under this standard. At the agency level, the agency head designee asserted they have several union contracts and that when a new contract is under negotiation, there is often a learning curve that is undergone to ensure the understanding of PREA requirements under this standard.

**Corrective Action:**

None required.

## Standard 115.267: Agency protection against retaliation

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.267 (a)**

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

**115.267 (b)**

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

**115.267 (c)**

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

**115.267 (d)**

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

**115.267 (e)**

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

**115.267 (f)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*
- *Inmate Protection Against Retaliation* form

- *Staff Protection Against Retaliation* form

**Findings:**
115.267(a)
ODOC PREA Policy OP 030601 *(p 21-22)* addresses this provision; protecting inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff, and mandates that the facility shall designate staff members charged with monitoring retaliation. CoreCivic APS OP 030601*(p 10)* charges the PREA compliance manager with ensuring that the designated staff member has completed the retaliation monitoring.

At the Carver Center, the PREA compliance manager is charged with retaliation monitoring and was interviewed by the auditor regarding this responsibility. He reported that the ACA compliance coordinator also shares this responsibility and that there had not been an allegation that required monitoring. The one allegation of sexual abuse resulted in both inmates being transferred out of the facility immediately.

115.267(b)
ODOC PREA Policy OP 030601 *(p 21-22)* addresses each element of this provision and specifies mental health services for inmate victims and the employee assistance program for employees that have experienced retaliation.

The PREA compliance manager explained in detail the protective measures in place for protecting staff and inmates from retaliation. There are two forms for documenting this process; *Inmate Protection Against Retaliation* and *Staff Protection Against Retaliation.* The agency head designee affirmed that the agency has a zero tolerance for retaliation, that after-action reviews look at retaliation, that communication from the staff or inmate victim is encouraged, and also cited examples of what retaliation may look like.

The facility head affirmed that the PREA compliance manager and ACA compliance coordinator are charged with retaliation monitoring, and that any suspected retaliation would be reviewed.

There were no inmates at the facility who had reported sexual abuse and, therefore, none could be interviewed to verify this practice.

115.267(c), (d)
ODOC PREA Policy OP 030601 *(p 22)* mandates that retaliation monitoring occurs for at least 90 days following the report of sexual abuse and also cites the items in this provision to monitor such as housing or program changes.

Though, retaliation monitoring had not yet been warranted, the PREA compliance manager explained in exceptional detail the procedures for doing so and things he would monitor for. Staff retaliation monitoring would entail: repercussions from supervisors, touching base in-person periodically, change in days or shifts, the assignment of additional or “less desirable” duties. Inmate retaliation monitoring would entail: review of disciplinary reports (ensuring they are justified), room assignments, periodic in-person status checks, level changes, check with the inmate’s case manager. Furthermore, he stated that if retaliation were suspected, they would take immediate action to remedy it; would consider a facility

move if necessary, although, best efforts would be made not to be punitive to the alleged victim. For staff, they also could be transferred or put on administrative leave if needed. Additionally, ODOC PREA Policy *(p 22)* mandates that if the inmate victim moves to another facility, notification will be made to that facility to inform of the continued need for monitoring.

The facility head provided general information about monitoring for retaliation but did not cite specific protective measures other than ensuring separation, review suspected retaliation, and follow up.

115.267(e), (f)
ODOC PREA Policy OP 03601 *(p 22-23)* address these provisions asserting that anyone who cooperates in a sexual abuse investigation is subject to retaliation monitoring and that the obligation to monitor will terminate if the OIG makes an unfounded determination. This policy language was corroborated by the PREA compliance manager. The facility head provided general information about monitoring for retaliation but did not cite specific protective measures other than ensuring separation, review suspected retaliation, and follow up.

**Corrective Action:**

None required.

# INVESTIGATIONS

## Standard 115.271: Criminal and administrative agency investigations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.271 (a)**

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).]
  ☒ Yes ☐ No ☐ NA

**115.271 (b)**

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

**115.271 (c)**

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

**115.271 (d)**

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

**115.271 (e)**

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

**115.271 (f)**

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

**115.271 (g)**

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

**115.271 (h)**

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

**115.271 (i)**

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

**115.271 (j)**

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

**115.271 (k)**

- Auditor is not required to audit this provision.

**115.271 (l)**

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? [N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- ODOC Security Policy OP 040117 *(effective 4/25/16)*
- *Administrative/Criminal Investigations Advise of Title 21, Section 281*
- Investigative Records and Documentation

**Findings:**

115.271(a)
ODOC Security Policy OP 040117 *(p 2)* addresses the investigation of allegations of sexual abuse and assault; mandating the agency do so promptly, thoroughly, and objectively.
The PREA compliance manager is charged with conducting administrative investigations of sexual abuse and sexual harassment. He explained in detail the process of doing so affirming the prompt, thorough, and objective manner. He also stated that if an allegation were criminal or potentially criminal in nature, he would refer it to the ODOC OIG; following notification protocol to CoreCivic leadership as well.

There was one allegation of sexual abuse during the 12-month pre-audit reporting period which was criminal in nature and was referred to the OIG for criminal investigation. It was an inmate-on-inmate allegation and determined to be unsubstantiated. Incident reports, *Serious Incident Data Report, Sexual Abuse Incident Review*, inmate notification, *Sexual Assault Report*, and the *PREA Response Checklist* comprised the investigative documentation. The PREA Response Checklist documented that the allegation was reported on 1/25/18 and that notifications to the warden, medical, mental health, chief of security, PREA compliance manager, and ODOC were made the same day. The *Serious Incident Database Report* also documented that the incident was referred to internal affairs (ODOC) the same day. The full investigative report was not available as it was not provided to the facility. Discussion with the PREA compliance manager indicated that the facility does not receive the full investigative report but that the facility head has the ability to review the investigation in person, if the facility chooses to do so. The PREA compliance manager expressed that information is shared with the facility about the progress of the investigation. It was unclear the exact date in which the investigation was closed, though the auditor was able to deduce that it was after 2/6/18 and prior to 3/16/18; indicated by review of the facility's sexual abuse incident review documentation.

115.271(b), (c), (j)
ODOC PREA Policy OP 030601 *(p 17)* states that specialized training is provided for employees that may respond to incidents of sexual assault and that the training may include (but is not limited to) crime scene management and elimination of contamination. Further it asserts that for ODOC inspector general agents this training shall include conducting sexual abuse investigations in confinement settings.

ODOC Security Policy OP 040117 *(p 2-3)* addresses provisions also; the investigation of allegations of sexual abuse and assault.

The two facility staff members (one being the PREA compliance manager) had completed the specialized training. The two designated investigators have also received the general PREA training as required by this standard. They are the designated trainers for PREA. The auditor was provided with documentation that agency, ODOC, as of May 2017 had 17 inspector general investigators that had received specialized training pursuant to this standard.

The PREA compliance manager articulated in detail the process of conducting a sexual abuse or sexual harassment investigation. He elaborated on the required specialized training elements; was cognizant of techniques for interviewing victims, of the criteria for substantiating allegations and/or referring them for criminal investigation. He also discussed conducting interviews with the alleged victim, witnesses, and alleged abusers, without judgement, and that this would occur and/or continue whether the inmate(s) left he facility or the staff member resigned.

For a further assessment of the specialized training for investigators see Standard 115.234 above.

115.271(d)
ODOC Security Policy OP 040117 *(p 7-8)* addresses interviews of employees. It states that when an interview is conducted, the interviewee will be informed of the nature of the interview; whether it is criminal administrative. It states that an employee that is suspected of criminal conduct shall be read the *Criminal Investigations Advise of Rights/Waiver or Consent* form. Policy language then further elaborates on the use and completion of this form. OP 040117 also states that pursuant to an official investigation, employees will be required to read and sign the *Administrative/Criminal Investigations Advise of Title 21, Section 281.* This form states, "Any person who knowingly makes or utters a materially false statement, either verbally or in writing, in the course of an internal state agency investigation shall, upon conviction, be guilty of a misdemeanor punishable by imprisonment in the county jail for not more than one year, or by a fine not exceeding $500.00, or by both such fine and imprisonment."

The PREA compliance manager stated that if there were any potential for criminal conduct, he would not be conducting interviews of a staff member.

115.271(e)
ODOC Security Policy OP 040117 *(p 8)* partially addresses this provision about assessing the credibility of an alleged victim. Page 9 outlines the polygraph program and states, in part, that sexual abuse victims are not candidates.

The PREA compliance manager (designated facility investigator) affirmed his practice of using an unbiased approach and that no truth-telling devices are ever used.

115.271(f)
Policy language relevant to this provision was not provided, though, the PREA compliance manager (designated facility investigator) articulated in detail the manner in which he would look for staff actions or failures that contributed to an act of sexual abuse. Further, he stated that such an investigation would be formally documented; capturing interview information, evidence, summary, and findings. Though, the one investigation of sexual abuse was referred for criminal investigation, the PREA compliance manager compiled an investigative file consisting of many documents such as a *Serious Incident Data Report, Sexual Abuse Incident Review*, inmate notification, *Sexual Assault Report*, and *PREA Response Checklist.*

115.271(g)
ODOC Security Policy OP 040117 *(p 9)* addresses this provision regarding the required information in a criminal investigative report and submission thereof. The PREA compliance manager stated that criminal investigations, which are completed by the ODOC OIG, are documented on a standard agency form. The facility does not generally receive the full investigative report which contains a full description of evidence, however. This would be available for the facility head or other agency leadership to review in person.

115.271(h)

ODOC Security Policy OP 040117 *(p 8-9)* addresses the filing of criminal charges but does not specifically address the requirements of this standard.

The PREA compliance manager expressed knowledge of the criteria necessary for substantiating an allegation and that substantiated allegations would be referred to the OIG for prosecution referral.

115.271(i)
ODOC Security Policy OP 040117 *(p 5)* cites the requirements of this provision; mandating the retention of investigative reports for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

115.271(k)
This provision has no bearing of compliance for this facility.

115.271(l)
Policy language relevant to this provision was not provided, though, the PREA compliance manager (designated facility investigator) expressed that the facility has no issue with remaining informed of the progress of an investigation, when conducted by an outside entity. Examples and documentation of this communication was evident upon review of the investigative documentation. The facility head explained that the facility checks in on the progress of an investigation and that it is necessary as sometimes it is a lengthy process. He corroborated that they have encountered no resistance remaining informed.

**Corrective Action:**

None required.

## Standard 115.272: Evidentiary standard for administrative investigations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.272 (a)**

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- Investigative records and documentation

**Findings:**

115.272(a)
ODOC PREA Policy OP 030601 *(p 6)* cites this standard; imposing a standard no higher than a preponderance of evidence.

This same standard of evidence was articulated in the interview with the PREA compliance manager (designated investigator) and he defined that standard as anything more than a 50% likelihood. Upon review of the one investigation, which was determined to be unsubstantiated, the case disposition appeared to be justified. There did not appear to be a preponderance of evidence, to substantiate the case.

**Corrective Action:**
None required.

## Standard 115.273: Reporting to residents

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.273 (a)**

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

**115.273 (b)**

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

**115.273 (c)**

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

**115.273 (d)**

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

**115.273 (e)**

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

**115.273 (f)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- Investigative Records and Documentation
- *Notification of Investigative Status* form

**Findings:**

115.273(a)
ODOC PREA Policy OP 030601 *(p 28)* cites this standard regarding the notification to inmate victims of the investigative outcomes. This notification is documented on attachment D of this policy: *Notification of Investigative Status.*

There was one allegation of sexual abuse during the 12-month pre-audit reporting period, which was referred for criminal investigation and determined to be unsubstantiated. Part of the investigative file included documentation of inmate notification of this outcome. The *Notification of Investigative Status* was completed as soon as the case was concluded, on 3/15/18. It referenced the case number and the unsubstantiated disposition and was signed and dated by the facility head.

The PREA compliance manager affirmed this practice and the use of the standard notification form. The facility head affirmed this practice as well, adding that even if the inmate releases the facility still attempts to provide this notification.

115.273(b)
Policy language relevant to this provision was not provided, though, review of the investigative file for the one sexual abuse investigation verified practice of obtaining relevant information from the outside investigating entity to inform the inmate, which is what occurred.

115.273(c), (e)
ODOC PREA Policy OP 030601 *(p 28)* mandates the notification as required by this provision. Furthermore, it asserts that the facility head shall inform the inmate whenever: (1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

The *Notification of Investigative Status* form has checkboxes to indicate that the staff member is: no longer posted in the inmate's living unit; no longer employed at the facility; has been included as a suspect in the case which was presented for prosecution to local authorities; or not applicable. Moreover, the form does not specifically indicate whether the staff member "has been indicted on a charge related to sexual abuse within the facility" or the staff member "has been convicted on a charge related to sexual abuse within the facility." While agency practice meets substantial compliance, the form could more distinctly demonstrate compliance with these two elements.

In the one sexual abuse investigation, the checkbox in this section was marked as not applicable since the allegation did not involve a staff member. The inmate victim in this case was no longer at the facility during the onsite audit and, therefore, could not be interviewed.

115.273(d), (e)
ODOC PREA Policy OP 030601 *(p 28)* mandates the notification as required by this provision; whenever the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility or that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. Policy charges the facility head with informing the inmate.

The *Notification of Investigative Status* form has checkboxes to indicate that the alleged abuser: has been included as a suspect in the case which was presented for prosecution, has been charged with a disciplinary violation institutionally, or not applicable. The form does not specifically indicate whether the alleged abuser "has been indicted on a charge related to sexual abuse within the facility" or "has been convicted on a charge related to sexual abuse within the facility." While agency practice meets substantial compliance, the form could more distinctly demonstrate compliance with these two elements.

In the one sexual abuse investigation, the checkbox in this section was marked as not applicable since the allegation was unsubstantiated and there were no indictments, convictions, or institutional violations. It was signed and dated by the facility head. The inmate victim in this case was no longer at the facility during the onsite audit and, therefore, could not be interviewed.

115.273(f)
ODOC PREA Policy OP 030601 *(p 28)* states that the obligation to notify inmates ceases if the inmate is released from custody.

The facility head indicated that the facility attempts notification even if the inmate releases, which exceeds this standard. Regarding the one investigation, the inmate was notified even though he was transferred. The notification form was completed and was signed by the facility head on 3/15/18 and signed by the inmate on 3/16/18.

**Corrective Action:**
None required.

# DISCIPLINE

## Standard 115.276: Disciplinary sanctions for staff

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.276 (a)**

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

**115.276 (b)**

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

**115.276 (c)**

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

**115.276 (d)**

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- ODOC Human Resources Policy OP 110215 *(effective 1/13/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*

**Findings:**

115.276(a), (b)
ODOC PREA Policy OP 030601 *(p 9)* addresses this provision in regard to staff discipline. Page seven asserts that termination is the presumptive discipline for staff engaging in sexual abuse.

CoreCivic APS OP 030601 *(p 13)* also cites this provision directly.

During the pre-audit reporting period, there were no allegations of staff sexual abuse or sexual harassment.

115.276(c)
ODOC Human Resources Policy OP 110215 *(p 3)* states that staff are subject to sanctions as outlined in the ODOC OP 110415 *Progressive Disciplinary Procedures;* ensuring that discipline for a staff member is commensurate with that of another, considering the nature of the violations.

CoreCivic APS OP 030601 *(p 13)* also cites this provision directly.

During the pre-audit reporting period, there were no allegations of staff sexual abuse or sexual harassment.

115.276(d)
ODOC PREA Policy OP 030601 *(p 11)* states that staff members "found guilty of committing sexual assault are disciplined in accordance with agency procedures and will be referred for criminal prosecution by the Office of Inspector General."

CoreCivic APS OP 030601 *(p 13)* also cites this provision directly and includes the reporting to relevant licensing bodies.

**Corrective Action:**

None required.

## Standard 115.277: Corrective action for contractors and volunteers

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.277 (a)**

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

**115.277 (b)**

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- *Pre-Audit Questionnaire* (PAQ)
- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- ODOC Volunteer Services Policy OP 090211 *(effective 1/19/17)*
- *Volunteer Alert Form*

**Findings:**

115.277(a)
ODOC Volunteer Services Policy OP 090211 *(p 14)* states that a volunteer must maintain professional inmate relations at all times and that violations "that suggest criminal activity" will be forwarded to local law enforcement authorities. It does not address the reporting to relevant licensing bodies. ODOC PREA Policy OP 030601 *(p 5)* also asserts that violations by employees (which volunteers and contractors are defined as) are subject to disciplinary action and referral for prosecution.

The PAQ indicated, as did the PREA compliance manager, there were no violations of sexual abuse and sexual harassment policies by contractors or volunteers. Therefore, there were no such records or documentation to review. The Carver Center does not utilize services of any contractors that have inmate contact.

115.277(b)
ODOC Volunteer Services Policy OP 090211 *(p 14)* states that in the event a volunteer violates a policy or rule, the facility head may suspend that volunteer's activity. Further it charges the facility chaplain or volunteer coordinator with completing and submitting the *Volunteer Alert Form.* This form documents the incident and action taken. The bottom of the form states that the form is to be submitted to the ODOC agency volunteer coordinator.

The facility head stated that, in this instance, the volunteer or contractor would be taken off the approved volunteer list and they would no longer have a badge, which ensures that entrance into the facility would be prohibited.

**Corrective Action:**
None required.

## Standard 115.278: Interventions and disciplinary sanctions for residents

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.278 (a)**

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

**115.278 (b)**

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

**115.278 (c)**

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

**115.278 (d)**

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the

offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

**115.278 (e)**

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

**115.278 (f)**

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

**115.278 (g)**

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- ODOC Disciplinary Procedures Policy OP 060125 *(effective 4/28/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*
- *Range of Allowable Sanctions*

**Findings:**
115.278(a)

ODOC PREA Policy OP 030601 *(p 11)* states that inmates and staff "found guilty of committing sexual assault are disciplined in accordance with agency policy." It does not speak to a formal discipline process, though, ODOC Disciplinary Procedures Policy OP 060125 outlines the formal discipline process for inmates. In addition, CoreCivic APS OP 030601 *(p 12)* cites this provision directly.

There was one allegation of inmate-on-inmate sexual abuse during the 12-month pre-audit reporting period, though, no discipline was issued. The investigation resulted in an unsubstantiated disposition and both inmates were subsequently transferred, due to unrelated matters. The alleged abuser was in process of being transferred due to other rule violations and the alleged victim was transferred to another facility for mental health evaluation and treatment.

115.278(b)
ODOC Disciplinary Procedures Policy OP 060125 outlines formal disciplinary procedures ensuring that discipline is issued in a consistent manner; commensurate with the nature and circumstances of the abuse committed, the inmate's disciplinary history, and the sanctions imposed for comparable offenses by other inmates with similar histories.

The facility head affirmed there were formal discipline procedures, that staff are trained on it, and that there is a staff designated as disciplinary chair that implements and oversees the process. The disciplinary officer was also interviewed, explained the formal discipline process, and discussed the sheet used for sanctions which lists a range of allowable sanctions.

115.278(c)
CoreCivic APS OP 030601 *(p 13)* cites this provision stating that the disciplinary process shall consider whether an inmate's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Such policy language was not provided or found in the discipline procedures policy.

The disciplinary officer stated that there was nothing official guiding this practice, but that he could use his discretion in considering an inmate's mental status. It is recommended that this consideration be more formalized.

115.278(d)
The Carver Center does not offer therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse. The facility does not offer medical or mental health services.

115.278(e)
CoreCivic APS OP 030601 *(p 13)* cites this provision stating that an inmate may only be disciplined for sexual contact with a staff member upon finding that the staff did not consent to such contact.

There were no allegations of sexual abuse involving staff.

115.278(f)
CoreCivic APS OP 030601 *(p 13)* addresses this provision and states that inmates may be disciplined for deliberately making false allegations. Furthermore, policy language states that the facility head or

designee should contact law enforcement to determine whether the false allegation is subject to prosecution.

**Corrective Action:**
None required.

# MEDICAL AND MENTAL CARE

## Standard 115.282: Access to emergency medical and mental health services

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.282 (a)**

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

**115.282 (b)**

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

**115.282 (c)**

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

**115.282 (d)**

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
  ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- ODOC Health Services Policy OP 140118 *(effective 1/18/17)*
- ODOC's *Inmates' Guide To Sexual Misconduct*
- MOU with YWCA

**Findings:**

115.282(a)
ODOC Health Services Policy OP 140118 *(p 4)* addresses this provision. Though the Carver Center does not provide medical or mental health services directly, the facility ensures that inmates have access to timely and unimpeded emergency medical services and crisis intervention. Medical services are obtained through the ODOC "host" prison facility; Clara Waters. Inmates can also be transported to the local hospital for emergency medical services including forensic exam. Crisis intervention services are provided via an MOU with the YWCA.

Medical and mental health staff were not interviewed since none are employed by the facility. Inmates who reported sexual abuse were not interviewed since there were none at the facility during the onsite audit. Review of documentation of the one allegation of inmate-on-inmate sexual abuse verified that the facility obtained timely and unimpeded emergency medical services by transporting the inmate immediately to the host facility Clara Waters.

115.282(b)
ODOC Health Services Policy OP 140118 *(p 4)* addresses this provision.

Evidence of this practice was reviewed by the auditor regarding the one sexual abuse allegation. Immediate and preliminary steps were taken by first responders to ensure inmate safety. Immediate notifications were made to the PREA compliance manager and subsequent notifications in accordance with agency policy and the coordinated response. This process was well documented on the incident reports, *PREA Response Checklist*, *Sexual Assault Report, and Serious Incident Database Report.*

115.282(c)

ODOC Health Services Policy OP 140118 *(p 3)* addresses this provision stating that inmates will be provided with timely access to emergency contraception and sexually transmitted infections prophylaxis.

Documentation of providing access to emergency contraception and prophylaxis was not available since the inmate refused to cooperate and was combative toward the nursing staff. The inmate had to be transferred to a higher level of care.

115.282(d)
ODOC Health Services Policy OP 140118 *(p 3)* asserts that treatment services are provided without cost to the inmate. The MOU with the YWCA specifies that no payment shall be exchanged. The ODOC's *Inmates' Guide To Sexual Misconduct* also informs inmates that fees for medical services related to sexual misconduct are waived.

**Corrective Action:**
None required.

## Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.283 (a)**

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

**115.283 (b)**

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

**115.283 (c)**

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

**115.283 (d)**

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

**115.283 (e)**

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

**115.283 (f)**

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

**115.283 (g)**

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

**115.283 (h)**

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☐ Yes ☒ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- ODOC Health Services Policy OP 140118 *(effective 1/18/17)*
- MOU with YWCA

**Findings:**

115.283(a), (b), (f)

ODOC Health Services Policy OP 140118 outlines emergency medical and mental health treatment, but not specifically ongoing treatment, though, page five does state, “Following the physical examination, there will be availability for an evaluation by a qualified mental health professional to assess the need for crisis intervention counseling and long-term follow-up.” Furthermore, it states that prophylactic treatment and follow up for sexually transmitted infections will be offered to all victims as clinically indicated.

In practice, ongoing medical services are provided by transporting the inmate to the host facility and crisis intervention and emotional support is provided by the YWCA by virtue of the established MOU. The MOU outlines these services.

115.283(c)
Policy language relevant to this provision, mandating a level of medical and mental health care consistent with a community level of care, was not provided.

As previously indicated, medical and mental health services are provided off site. Policy specifies that these services will be provided by qualified mental health professionals and email communication from a YWCA representative affirmed the qualifications of the YWCA personnel.

Medical and mental health staff were not interviewed since the Carver Center does not employ such staff and do not offer such services onsite. Though not directly asked, two inmates mentioned that it takes a long time to have a medical request tended to. One of them said, “It takes weeks to get to the doctor.” Without being able to interview medical staff, this could not be corroborated or verified.

115.283(d), (e)
These provisions are not applicable since the Carver Center is an all-male facility.

115.283(g)
ODOC Health Services Policy OP 140118 *(p 3)* asserts that treatment services are provided without cost to the inmate. The MOU with the YWCA specifies that no payment shall be exchanged. The ODOC’s *Inmates’ Guide To Sexual Misconduct* also informs inmates that fees for medical services related to sexual misconduct are waived.

115.283 (h)
Policy language relevant to this provision was not provided, in regard to conducting an evaluation of known inmate-on-inmate abusers. The Carver Center does not provide mental health services onsite and it was unclear whether an evaluation under this provision would be obtained. As reported by the case managers and intake staff interviewed (those that conduct the sexual abuse risk screening tool), the facility has had no such known abusers. Additionally, due to the step-down nature of this facility, if a known inmate-on-inmate abuser was discovered, the inmate would not be eligible for placement and would be transferred. The requirement of an evaluation of this nature would not be warranted at this facility.

**Corrective Action:**
None required.

# DATA COLLECTION AND REVIEW

## Standard 115.286: Sexual abuse incident reviews

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.286 (a)**

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

**115.286 (b)**

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

**115.286 (c)**

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

**115.286 (d)**

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

**115.286 (e)**

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- *Sexual Abuse Incident Review*
- Investigative Records and Documentation

**Findings:**

115.286(a), (b)

The facility conducts a sexual abuse incident review at the conclusion of every substantiated and unsubstantiated sexual abuse investigation. This was evidenced in practice and is guided by ODOC PREA Policy OP 030601 *(p 28-29).*

There was one allegation of inmate-on-inmate sexual abuse, reported on 1/25/18. A sexual abuse incident review was conducted twice; once while the investigation was still pending (on 2/6/18) and again once it was determined to be unsubstantiated (on 3/16/18).

115.286(c)

ODOC PREA Policy OP 030601 *(p 29)* addresses this provision stating that the review team shall consist of administrative staff with input from line supervisors, medical/mental health staff, investigators, and the PREA compliance manager.

Review of the completed reviews affirmed participation by the required parties and as specified in policy; PREA coordinator, PREA compliance manager, facility head, case manager, and operations supervisor. The facility head, when interviewed, confirmed his participation in the review.

115.286 (d), (e)
ODOC PREA Policy OP 030601 *(p 29)* cites this provision by outlining all required elements of the review.

Sexual abuse incident reviews are documented on the *Sexual Abuse Incident Review* document. This document captures the case number, type of allegation, review team members, an assessment of the location of the incident, an assessment of the motivation for the incident, staffing levels in the area, the need for deploying or augmenting monitoring technology, need for changes to policy or practice, recommendations and timeframe for implementing, and reasons for not implementing recommendations (if applicable). The PREA coordinator and PREA compliance manger were part of the review and the document was signed by the facility head.

The PREA compliance manager was interviewed as a review team member and explained the review having discussed the incident in detail; the location of the incident (in the back of the dorm) and camera coverage, options to improve lighting or the use of mirrors to aid in camera visibility. He explained that video footage was reviewed but the visibility was minimal. The facility head discussed the purpose of such reviews being to uncover any possible adjustments needed to procedures.

The facility exceeds this standard due to the practice of conducting the review on more than one occasion, for well-demonstrated practice via documentation, as well as the articulation of the review process.

**Corrective Action:**
None required.

## Standard 115.287: Data collection

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.287 (a)**

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

**115.287 (b)**

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

**115.287 (c)**

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

**115.287 (d)**

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
  ☒ Yes ☐ No

**115.287 (e)**

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

**115.287 (f)**

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
  ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- *Survey of Sexual Victimization* (SSV)
- *Sexual Assault Report*
- *Sexual Abuse Incident Review*

**Findings:**

115.287(a), (b), (c), (d)
ODOC PREA Policy OP 030601 *(p 30)* addresses the collection and aggregation of sexual abuse data. CoreCivic APS OP 030601 *(p 17)* addresses the collection and use of data as well specifying that it shall include, at minimum, all categories of data necessary to respond to the Survey of Sexual Victimization (SSV).

This data was collected, and was reviewed, on the ODOC's *Sexual Assault Report,* which indicates on page two whether the incident is: inmate-on-inmate sexual harassment, inmate-on-inmate nonconsensual sexual act, inmate-on-inmate abusive sexual contact, staff sexual misconduct, or staff sexual harassment. These categories comprise what is necessary to complete the SSV. The *Sexual Abuse Incident Review* document captures the same categories. The most recent completed *Survey of Sexual Victimization* (2016) was provided for review as well.

The PREA coordinator collects and aggregates all department sexual abuse and sexual harassment data on an ongoing basis.

115.287(e)
ODOC PREA Policy OP 030601 *(p 31)* states that the agency will collect incident-based and aggregated data from private facilities with which it contracts. This is accomplished via the *Sexual Assault Report* that are completed at the facilities and submitted. The PREA compliance manager and PREA coordinator discussed this requirement; being two tracks of reporting data and incidents, to ODOC as well as to CoreCivic.

115.287 (f)
This provision has no bearing on compliance since the Department of Justice has not requested sexual abuse data.

**Corrective Action:**
None required.

## Standard 115.288: Data review for corrective action

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.288 (a)**

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

**115.288 (b)**

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

**115.288 (c)**

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

**115.288 (d)**

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic *2016 PREA Annual Report*
- CoreCivic Agency Website

**Findings:**

115.288(a), (b), (c)
CoreCivic APS OP 030601 *(p 17-18)* addresses data review pursuant to this standard; identifying problem areas, taking corrective action, and preparing an annual report.

The auditor was provided with the CoreCivic's *2016 PREA Annual Report*. The report contains information on the scope of the report, definitions of sexual abuse and sexual harassment (as defined in the PREA Standards), data collection methods and efforts, audits completed, corrective action taken, and

data comparison between 2014, 2015, and 2016. It is a detailed report that contains detailed data; breaking it down by facility type (prisons/jails and community confinement) and then by incident type (staff-inmate sexual abuse, staff-inmate sexual harassment, inmate-inmate sexual abuse, inmate-inmate sexual harassment) and then by case disposition (substantiated, unsubstantiated, unfounded). The report includes narrative portions explaining agency PREA efforts and the collection, review, and trends in data. The report also depicts trends in substantiated incidents; showing a minor increase from 2014 to 2015 and again from 2015 to 2016. The detail, data, and information contained in this report exceeds this standard.

The report was created by the CoreCivic PREA coordinator. The first page and summary of the *2016 PREA Annual Report* contains the signature of the executive vice president and chief corrections officer; Harley G. Lappin.

CoreCivic PREA Annual Reports from 2013-2016 are posted on the agency public website: http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea

The agency head designee, Steven Conry, elaborated on the agency's use of sexual abuse and sexual harassment data to continually improve PREA efforts. He further explained the type of data that is collected; expressing familiarity with the annual report data, and the agency's data-driven approach; detecting trends and using that to identify needed corrective action.

115.288(d)
ODOC PREA Policy OP 030601 *(p 18)* cites this provision, stating the agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted. The PREA coordinator indicated that it has not yet been necessary to redact information from the annual reports.

**Corrective Action:**
None required.

## Standard 115.289: Data storage, publication, and destruction

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

#### 115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

#### 115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

**115.289 (d)**

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- *Pre-Audit Questionnaire* (PAQ)
- ODOC PREA Policy OP 030601 *(effective 7/17/17)*
- CoreCivic APS OP 030601 *(effective 4/04/16)*

**Findings:**

115.289 (a)
ODOC PREA Policy OP 030601 *(p 31)* states that data will be securely retained. This was corroborated by facility and agency practice. CoreCivic APS OP 030601 *(p 17)* states, "Data collected for this purpose shall be securely stored and retained in accordance with the facility's record retention policies."

115.289(b)
ODOC PREA Policy OP 030601 *(p 31)* states that data will be made available on the public website and updated annually. It does not make reference to data from facilities with which it contracts, though, review of the website …

CoreCivic APS OP 030601 *(p 17)* states, "The FSC PREA Coordinator shall make all aggregated sexual abuse data available to the public at least annually through the CoreCivic website." Review of

the CoreCivic website affirmed the availability of the sexual abuse data and the data was made available annually as evidenced by the *PREA Annual Reports* from 2013-2016.

115.289(c)
ODOC PREA Policy OP 030601 *(p 31)* states that “individually identifying information will be redacted.”

Review of the data on the ODOC website revealed no personal identifiers.

CoreCivic APS OP *(p 17)* states, “Before making aggregated sexual abuse data publicly available, CoreCivic shall remove all personal identifiers.”

Review of the data on the CoreCivic website revealed no personal identifiers.

115.289(d)
ODOC PREA Policy OP 030601 *(p 31)* states that data will be maintained for at least ten years after initial collection. Ten years has not yet passed for actual verification.

CoreCivic APS OP 030601 *(p 17)* states, “Data collected for this purpose shall be securely stored and retained in accordance with the facility's record retention policies.” The PAQ indicated that CoreCivic retains data for at least years, in accordance to this provision.

**Corrective Action:**
None required.

# AUDITING AND CORRECTIVE ACTION

## Standard 115.401: Frequency and scope of audits

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.401 (a)**

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

**115.401 (b)**

- Is this the first year of the current audit cycle? (*Note: a “no” response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the

agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

**115.401 (h)**

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

**115.401 (i)**

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

**115.401 (m)**

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

**115.401 (n)**

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- None

**Findings:**

Through discussions with the PREA coordinator, the auditor learned that the agency, CoreCivic, ensures that one-third of their facilities are audited each year and the PREA coordinator is charged with this responsibility. The PREA coordinator and auditor discussed some logistics and challenges related to making this happen.

The auditor observed all areas of the facility, which included any and all areas in which the auditor requested to see. The agency and facility was very accommodating with all documentation requests. Interviews were conducted in private settings; without being heard by others. All information obtained and observation by the auditor supported the fact that inmates were permitted to send confidential correspondence to the auditor, although, no correspondence was received.

**Corrective Action:**

None required

## Standard 115.403: Audit contents and findings

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.403 (f)**

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's*

*conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**The following evidence was analyzed in making the compliance determination:**

- Final PREA audit reports on agency website

**Findings:**

Upon review of the agency website, the auditor confirmed that all PREA auditor reports, from all CoreCivic facilities, are posted publicly.

**Corrective Action:**

None required.

# AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

## Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Talia Huff 6/28/18

**Auditor Signature** **Date**

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.